Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. MEND_ITEM#1perPHYS_G899_1 / 26 / 2010, WS State of Marviand / Department of Health and Mental Hygiene Certificate of Death Reg. No. Nadine Karen Whipple 2. Date of Death Physician/ onth Day JANUARY Month 18. 20 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b City Town, or Location of Death 4c. County of Death Cente Towson Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 - M 2 - F Months Days Hours Min. 215-68-2296 53 JUIV#26ay, 1956 Pennsylvania Director Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director 10d. Inside City Limits Maryland N/A Baltimore 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2908 East Cold Spring Lane 21214 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. ģ 1 Never Married 2 X Married Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2XX No Specify: If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Settlement Clerk H & S Bakery permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, tt once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Francine Graeber Campbell 2 James Lewis Foltz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2908 East Cold Spring Lane Baltimore Maryland 21214 Ernest G. Whipple/Husband 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
Hilltop Service Corp. 1 Burial 2 X Cremation 3 Removal from State 1/22/10 Towson Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses 22.Nameand jodress of Facility Leonard J. Rück, inc. 5305 Harford Road Baltimore Maryland 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ DISSEMINATED PLASMACYTOMA disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner Due to for as a consequence off if any leading to in mediar cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last nding physician and use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) Month Year 1 Yes 2 Unknown the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by SEPSIS Completed 2No 3 Probably 4 Unknown PNEUMONIA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy 1 Yes 2 No certificate 1 Yes 2 🛛 To the Hospital or Attending Physician; To Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Tyes 2 D No Other: 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral di 1 Appatient 2 ER/Outpatient 3 DOA Manper of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural
Accident
Suicide 5 Pending 1 ☐ Yes 2 ☐ No Investigation
6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 29a. Certifier 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 19 10 D37254 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7 HUH LIM. M. D. 7601 OSLER DRIVE TOWSON 31. Date filed (Months) MORYL OND State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Josephine Rebecca Walker January 2010 1:30p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 5737 Oakland Road Sykesville Carroll If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 □ M 2 □ √F 176-01-1668 Director 22 Oct. 1912 Usual Residence of Decedent filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evanine must be positived at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Carroll Sykesville Director 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5737 Oakland Road 21784 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. 1 ∏Yes 2 1 No If Yes, Give Y Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ∐Yes 2 No Specify ≥ Specify: white 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) music education piano teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ethan Allen Hubley Myrtle Mae Stees 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Bonnie Kane (daughter) 5737 Oakland Rd., Sykesville, MD 21784 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) York, PA Greenmount Cemetery 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licenses Pargrafarght 54 erbert P.O. Box 195 Sykesville, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ementia disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician the use as IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? for Month Year Day 9 Unknown à signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 autonsy perform certificate ! 2 1 1 ☐ Yes 2 ☐ No 1 ☐ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No After this 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No after death the 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated.

To the Hospital within 24 hours a To the Funeral L

101 State

William Jan 31. Date filed (Month, Day,

29b. Signature and title

045 Registrar's Signatu

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Registrar

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Medical Exami	ner			Willia		Jr			4, 2010	rear/	1859 hrs		
)		4a. Facility Name (if not institution, give stre 2001 University Avenue	et and number)		4	b. City, Town, or Federalsbu		eath	1	4c. County of Death Caroline			
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2121 ould be f I Mental marked ic event,	TO B	19a. Informant's Name/Relationship (Type,		19	b. Mailing	Address (Stree			Number, City or To	own, State	Zip Code)		
and 2 shou fealth and 1 tem 27 is r traumatic		Frank L. William 20a. Method of Disposition	ıs, III	-Son 2	209 1	/esper	Avenu	e Fede	ralsbur	g, N	ID 2163	32	
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Balt permit, Depart Import injury		21 Signature of Funeral Service Licensee	Atra L		Mar 110	me and Address Ch East North	Funera	1 Home	e, MD 21	202			
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/Medi_al Examiner		mediate Cause (Final disease a. D	iabetic		idosi	S	<u>-</u>				Death		
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Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the b	ΣI	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcom Live birth	e of pregnancy		al death 3	Ectopic pre	gnancy	23d. Date Month	of delivery D	ay Ye	ear	
OX 6 eath cer attend	sicia	1 Yes 2 No 9 Unknown 9	Pregnant at t	ime of death	5 Oth	er (Specify)							
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Division of Vital Records, P.O. Ital or Attending Physician: The law requires that the start death. In Director: After this certificate has been signed by the funeral director, page 2 should be detailed in by the funeral director, page 2 should be detailed.	P	1 ✓ Yes 2 No	28a. Date of Injur		utpatient Time of In		Other Nu	rsing Home 5	Residence 6		Scene		
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		his his	Vin)			O.C.I	M.E.		January 5	5, 2010			
d		30. Name and address of person who comp											
Ψ	2/2	Ling Li, MD Assistant Medic 31 Date filed (Month Day, Year)	32. Registrar		n Street	, Baltimore,	MD 21201						
St Regist			ereva	Signature	a. 40 1	6							

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Amend PI line b, 27,28a-f, per MF 9910 12/6/10 TT

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 00:22 AM Marie Anna Waring 2010 JANUARY 10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPITAL BALTIMORE SAINT AGNES If Under 1 Year | If Under 24 Hrs. | 9. Birthplace (State or Foreign Country)
Maryland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1 □ M 2 🛛 F 90 Yrs 11/29/1919 214 01 8617 Director Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f show Examiner must be retiffed at 1 □Yes 2 X No Funeral Director Baltimore Catonsville Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 715 Maiden Choice Lane Parkview 613 21228 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Never Married 2 ☐ Married 3altimore. Maryland 21215-0036 1 ☐ Yes 2 X No Specify. <u>م</u> Specify: 3 XWidowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 9th College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Howard Lillian Hoffnagle ည permit. Pages 1 and 2 & Department of Health an Important: If item 27 is m. any injury or other*** 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2827 Florida Avenue Patricia McGrane / Daughter Baltimore, Maryland 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Maryland 01/14/2010 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Gonce Funeral Service, P.A. romerouski 4001 Ritchie Highway Baltimore, Maryland 21225 23. Part 1. Enter the disea e, or confidence that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician PNEUMONIA disease or condition resulting in death) DAYS /Medical Due to (or as a consequence of): Examiner Hip Fracture Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last CERTIFICATION APPROVED BY MEDICAL EXAMINER Examiner Due to (or as a consequence of) al or Attending Physician: The law requires that the death certificate be executed after death.

I Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 XNo Month Day Year 5 Other (specify) o. 9 Unknown 9 Unknow ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Be Completed by CHRONIC OBSTRUCTIVE PULMONARY 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? OSTEOPOROSIS 24a. Was an 2 XNo 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Chatural 5 Pendina 2 Accident 1 ∏Yes 2 No subject fell investigation Jan. 2010 unk 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28t. Location (Street and Number or Rural Route Number, City or Town, State) 715 Maiden Choice Ln. Catonsville, MD 4 Homicide determined Assisted Living Facility within 24 hours To the Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier January 10th, 2010 adricker, M.D P22006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RADHIKA KALISETTI, 900 CATON AVENUE, BALTIMORE, MD 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

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Physicia		State Registrar 1. Decedent's Nam	,	, Last)		Cei	rtificate of	Death	2. Date of De Month	Reg. No. eath Day	Year	r	3. Time o		
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hysician /Medical xaminer	dical Examiner	21. Signature of Euneral Service State Anatomy Board 655 W. Baltimore Street 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part 1 Enter the dise se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):													
attending for use as	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Live birth 2 □ Fetal death in the past 12 months? 1 □ Live birth 2 □ Fetal death 5 □ Other (specify) □ 1 □ Live birth 2 □ Fetal death 5 □ Other (specify) □ 1 □ Live birth 2 □ Fetal death 5 □ Other (specify) □ 1 □ Live birth 2 □ Fetal death 5 □ Other (specify) □ 1 □ Live birth 2 □ Fetal death 5 □ Other (specify) □ 1 □ Live birth 2 □ Fetal death 5 □ Other (specify) □ 1 □ Live birth 2 □ Fetal death 5 □ Other (specify) □ 1 □ Live birth 2 □ Fetal death 5 □ Other (specify) □ 1 □ Live birth 2 □ Fetal death 5 □ Other (specify) □ 1 □ Live birth 2 □ Fetal death 5 □ Other (specify) □ 1 □ Live birth 2 □ Fetal death 5 □ Other (specify) □ 1 □ Live birth 2 □ Fetal death 5 □ Other (specify) □ 1 □ Live birth 2 □ Fetal death 5 □ Other (specify) □ 1 □ Live birth 2 □ Fetal death 5 □ Other (specify) □ 1 □ Live birth 2 □ Fetal death 5 □ Other (specify) □ 1 □ Live birth 2 □ Fetal death 5 □ Other (specify) □ 1 □ Live birth 2 □ Fetal death 5 □ Other (specify) □ 1 □ Live birth 2 □ Fetal death 5 □ Other (specify) □ 1 □ Live birth 2 □ Fetal death 5 □ Other (specify) □ 1 □ Live birth 2 □ Fetal death 1 □ Live birth									-				
been signed by the	ģ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to significant conditions contribute to significant conditions. 1 Yes 2 No 3 P													
certificate has buriector, page 2 sh	Completed	24a. Was an autopsy performed? 1 □ Yes 2 No 1 □ Ye									autopsy findings available o completion of cause of ? es 2 \(\square\) No				
ofter this	Certification: To Be	25. Was case referexaminer? 1 Yes 2 27. Manner of Deat 1 Natural 2 Accident	KNo	28a. Date of (Month)		ER/Outpatier 28b. Time of Injury	28c. Inju		ath <i>(Check only</i> Home 5 ☐ Res 28d. Describe	sidence 6		pecify)			
12 Hours of Ariental of the full of the fu	Certifica	3 Suicide 4 Homicide	6	ned 28e. Place of	f Injury - At h	ome, farm, str fy)	eet, factory, office		28f. Location City or To	(Street and wn, State)		Rural F	loute Nu	mber,	
Funer Funer rely fil	edical	29a. Certifier (Check only one)	Certifyin 2 Medical I	g Physician: To the b Examiner: On the bas and manne	is of examina	owledge, deat ation and/or in	h occurred at the vestigation, in my	time, date and plac opinion, death occ	e, and due to the urred at the time	e cause(s) e, date and	and manner place, and d	as stat	ed. ie cause	(s)	
within 2 To the I	Σ	29b. Signature and	title of certifier	MAR	Trus	3	29c. Licer	DUS9	33	29d. Dat	e signed (Mo	nth, Da	y, Year)		
Stat	е	31. Date filed (Mon	nth, Day, Year	who completed cause	distrar's Signa	010]		AN'S LA	NE E	ASIC	IN MI	2	210	601	
Registra	ır	31	AN 202	010 Des	u d	. pa	1000								

Registrar DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 20b per FH 9899 1/20/10 TT State of Maryland / Department of Health and Mental Hygiene 0 | 0 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 41 A M Year Month **Physician** WILSON -ON ZO JANUARY 20/0 /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SECOMPS HOSPITAL BACTIMORE 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Months Days 216-34-6011 1**X** M 2□ F Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Oppertment of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, he mortan Ecarnica count to norified at Battimore 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Warwiek Avenue USA Funeral 12. Was Decedent Ever in U.S.
Armed Forces?
1 ★ es 2 □ No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐Yes 2 No ۵ 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. po NOT use retired)

Methanic Elementary/Secondary (0-12) College (1-4or 5+) Seaks 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Çode) 5300 Wilson Son Overhill Road 20b. Place of Disposition (Name of cemetery, crematory or other p 1/27/10 Burial 2 Cremation 3 Removal from State Donation 5 ☐ Other (Specify) of Funeral Service Ligensee Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, series of the disease. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PESPINATORY **Physician** FAILURE /Medical Due to (or as a consequence of): Examiner -UNG Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner executed and burial-trar Due to (or as a consequence of): Box 68760 physician The law requires that the death certificate be Physician/Medical the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 ☐ Other (specify) P.O. the 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l page 2 s autopsy performed?

1 Yes 2 No certificate I 2 🗆 No Division of Vital 1 ☐ Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this (Certification: To After thi funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) D30272 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSPITAL BACTIMONE, MARYLAND BON 5 THomas 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death edent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 20:02 PM 2010 01 Medical 4a. Facility Name (if not institution, gir **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Huspital Ball more Good Samantan 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔀 F Hours Country) 15-30-7845 Director 28a-f show 10c. City, Town or Location 10d. Inside City Limits any injury or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? ö Funeral Was Deceud.
Armed Forces?
Ves 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, White, etc. permit. Page 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or i Completed by 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify. 3 Widowed 4 □ Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Be 18. Mother's Name (First, Middle, Maiden Surname) Informant's Name/Relationship (Type, Pfil) aug Lfor 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ti'more Baltimore, 20b. Place of Disposition cemetery, cremater Ameral Service Licens 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Aspiration neimorria Priysician disease or condition Medical resulting in death) Due to (or as a consequence of): ^{*}Examiner Renal cute Sequentially list conditions, Examine cause. Enter Underlying Due to (or as a consequence of). Cause (Disease or linjury that initiated events or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IE FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Li Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Pregnant at time of death 9 Unknown P.O. been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Cerebro vascular Accident Division of Vital Records, 4. Unknown Completed 2 No 3 Probably Atheroselerosia 24a. Was an Were autopsy findings available prior to completion of cause of has autopsy performed' death? certificate 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral funeral 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 23986 UMPS 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joek Rawen Blud 560i , Rudrappa Good Samanitan Hospital BOREH MOTE MD 21239 31. Date filed (Month, 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Day **Physician** 3 40 Am M JAN 2010 Nancy Jane Warner /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Bel-AIN Harfor Bolaw tealth & Rehobilitation Center If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 1 □ M 2X F 23, Director 179-20-8601 1930 Virginia Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. em 27 is marked other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 □Yes 2 🛣 No Directo <u>Maryland</u> Harford Abingdon 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21009 USA Funeral 3313 Trellis Lane Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 No Baltimore, Maryland 21215-0036 1 ☐Yes 2 No ð 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 <u>Nurses Aide</u> Nursing Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be Health and Mental Raymond (unk) Riddle Blanche (unk) Wine 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2
Department of Health a
Important: If Item 27 is
any Injury or other tran-2215 Brigade Road, Enola, Pennsylvania, 17025 Wanda E. Gruver / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Jacob's Stone Ch. 1/19/2010 | Glenville, Pennsylvania 4 ☐ Donation 5 ☐ Other (Specify) Service Digensee of Funera 22. Name and Address of Facility McComas Funeral Home, P.A. 1 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complication of hat shock, or heart failure. List only one cure of aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 105 disease or condition resulting in death) /Medical s consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician be Physician/Medical The law requires that the death certificate IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ş Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 2 🗆 No 1 □ Yes 1 □ Yes Vital Physician: 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 HNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To of 28a. Date of Injury (Month, Day, Year) 27. Man or of Death e Hospital or Attending P 124 hours after death, e Funeral Director: After t 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division Natural Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the I 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar 30. Name and add

ress of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month Yound 1421 **Physician** Cheryl Angel (8 2010 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner HOWARD HOWARD CO. GE Birthplace (State or Foreign Country) If Under 1 Year 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 🕱 F 54 214 66 4529 12 MAR Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mernal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show amounts in the Important traumatic event, the Modical Examiner must be notified at once. 1 Yes 2 No BALTIMORE Funeral Director mo BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21244 NTWELL ROAM 610 14. Race - American Indian Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 XÎNo Specify: Specify: BLACK þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) MONTGOMERY Elementary/Secondary (0-12) College (1-4or 5+) -OPERATIVE SCREENINGCLK General HospiTAL 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be BRIGHT, SR P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) SPRINGS OR ELLICOTT CITY MO 21043 TANISSA DANGHTER 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a, Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 122/2010 MARRIOTSVILLE, MO ST LAWIN MEM GAL! 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee

22. Name and Address of Facility

23. Name and Address of Facility

24. Name and Address of Facility

25. Name and Address of Facility

26. OF SYKESVILLE RO ELDENSE

26. Name and Address of Facility

27. Name and Address of Facility

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29. Name and Address of Facility

21. Signature of Facility

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26. OF SYKESVILLE RO ELDENSE

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27. Name and Address of Facility

28. Name and Address of Facility

29. Name and Address o 22. Name and Address of Facility Julyunswy FH & nov Co-SYKESVILLE RO ELDERSBURG MO 21784 Approximate Interval Between Onset and Death Immediate Cause (Final arrythmid 72 Wr Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d, Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗆 Ectopic pregnancy Month Year 5 ☐ Other (specify) I∐Yes 2∐″No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l page 2 s autonsy performed' r this certificate h 2 PNo 2 PNo 1 ☐ Yes 1 ☐ Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After 5 Pending investigation 1 ☑ Natural 1 ☐ Yes 2 ☐ No n 24 hours after death.

le Funeral Director: / 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier DOO 66 515 18 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Vishi

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State

Registrar

31. Date filed (Month, Day, Year)

JAN

32. Registrar's Signature

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month UARY Day Jeffrey Wilson Atterbury Year 1 2 12:30 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death, Baltimore Center Joseph Medical Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Jan. 29 6. Sex 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** 1**√2√**M 2 □ F Days Hours Min. 214-90-3959 **Director** 55 954 Maryland Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo Maryland Anne Arundel Annapolis 1 ☐ Yes 2XXNo 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 2059 Maidstone Farm Road Funeral 21409 ould be filed within 72 hours after death with nd Mental Hygiene.

marked other than "natural", or items 23a U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. à 1 X Never Married 2 Married 1 Yes 2 No If Yes, Give Maryland 21215-0036 1 Yes 2 No Specify: White Specify: 3 Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) N/A N/A N/ABe 17. Father's Name (First, Middle, Last) 2 should be file and Mental H 18. Mother's Name (First, Middle, Maiden Surname) Gerald Atterbury Katherine Wilson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is any injury or other trau Gerald Atterbury/father 2059 Maidstone Farm Road Annapolis, Maryland 21409 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Atlantic Crematory 1/5/2010 4 Donation 5 Other (Specify) Glen Burnie, Maryland 21. Signatur Funeral Service Licensee John M. Taylor Funeral Home 22. Name and Address of Facility 0 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ BILATERAL PNEUMONIA disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner TRACT INFECTION HRINARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of). Exami and resulting in death) Last Due to (or as a consequence of): burialphysician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 the attending plant of the design of the des IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) Pregnant at time of death detached 9 Unknown P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed 23e. Did tobacco use contribute to the cause of death? þ s been signer should be Division of Vital Records. DOWN SYNDROME 1 Yes 2 X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autops, performed? death? this certificate 1 ☐ Yes 2 X No director, 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? 2 🛚 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes ၉ 1 🗴 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA funeral 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 XNatural 5 Pending (Month, Day, Year) work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: All completed filled in by the fu Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dal, Year) M.D 20101 41410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7601 OSLER DRIVE. TOWSON. MARYLAND 21204 M. D. 31. Date filed (Month, Day, Year)

JAN 0 4 2010 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year REZAZADEH **Physician** JAN. 04 2010 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner PINDELL HOWARD CHASE FULT 9. Birthplace (State or Foreign Country) TRAM If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 🔭 F 79 218-55-2911 DEC.OS Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination and injury or other traumatic event, the Medical Examination and once. 1 Yes 2 No Director HOWARD FULTON MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2075 IRAN PINDELL CHASE 11724 Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: White ģ 3 Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOME HOME MAKER OWN 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be SHEKAR REZAZADĒH 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) POTOMAC MD. 20854 11331 ALBERMYRTLE RD. SON FARHAD DAVARYA Saltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition NORBEK MEM. PARK 01/05/2010 OLNEY. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility ADEN MUSLIM FUNERAL SER 21. Signature of Finneral Service Licenses 1242 EASY ST. WOODBRIDGE VA. 22191 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 7 months Y Our 1 Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner that the death certificate be executed burial-trar Due to (or as a consequence of) Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Dav Year 5 Other (specify) □Yes 2 No P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Hospital or Attending Physician: The law requires 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? has certificate 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home Residence 6 Other (Specify) Hospital: 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? After 1 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) columbia mo 32. Registrar's Signatur (Month, Day, State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death NOREWS Physician/ Year DULTON Month ni Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Arbor at Baywoods Annapolis Anne Arundel . Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Year) 19<u>19</u> 90 Months 1 2 M 2 D F 072-18-7511 Yrs Connecticut Director Usual Residence of Decedent Hygiene. other than "natural", or items 23a or 28a-f shovent, the Medical Examiner must be notified at. 10b. County within 72 hours after death with the Maryland 10a State 10c. City. Town or Location 10d. Inside City Limits Director Annapolis Maryland Anne Arundel 1 Ves 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21403 Funeral 7101 Bay Front Drive #325 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc 1 Never Married 2 X Married 호 Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: White Specify: Completed 3 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) should be filed within and Mental Hygiens Emissary State Department Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be 1 Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evo 0 Archie Moulton Andrews, Sr. Eleanor Underwood 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7101 Bay Front Drive #325 Annapolis, MD 21403 19a. Informant's Name/Relationship (Type, Print) Dorothy Andrews/wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🛣 Burial 2 □ Cremation 3 □ Removal from State Putnam Cemetery 1/7/2010 Greenwich, CT 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on such line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examir The law requires that the death certificate be executed burial-transi Cause (Disease or injury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year the Unknown detached 9 Unknown signed by the Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4-☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performe • Hospital or Attending Physician: The 24 hours after death. • Funeral Director: After this certificate b 2 No 1 Tes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) HEARES Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 No မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Investigation
6 Could not be 1 🗌 Yes 2 🗆 No Accident
Suicide the f 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. сопріете The defical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated
Certifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 only one) 29b. Signature and title of certified pleted cause of death (Item 23a) (Type, Print) EN 31. Date filed (Month 32. Registrar's Signature State 5 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** Atkinson Wayne 6:55 Α Harry January 2 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 10109 Hillcrest Drive. Cumberland Allegany If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 87 Director 02/24/1922 Maryland <u> 220-07-6367</u> Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner mast be recified at 1 ☐Yes 2 ☐No MD Director Allegany Cumberland the 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hyglene.

Important: If item 27 is marked other than "natural", or items 23a or 2 and 1 injury or other traumatic event, the Mental Experimental once. 10109 Hillcrest Drive, NE 21502 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever în U.S. Armed Forces? 11. Marîtal Status 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1942-1 □Yes 2 ☑ No Specify: ģ White 3 Widowed 4 Divorced 1945 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Machinist Tire and Rubber 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Clarence Oscar Atkinson Minta Mae Davis ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Lois Atkinson / Wife 10109 Hillcrest Drive, NE, Cumberland, MD 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MD Vet Cem @ Rocky Gap 01/05/2010 Flintstone, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, MD 1 10g Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final disease or condition resulting in death) ONGESTIVE **Physician** EAKS /Medical Due to (or as a consequence of): Examiner BARS Due to (or as a consequence of): ocquentiany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trai Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 - Ectopic pregnancy in the past 12 months? 5 ☐ Other (specify) 1 □Yes 2 □ No the 9 ☐ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>S</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe certificate 1 ☐Yes 2 ☐No 1 ☐Yes 2 ☐No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 M Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA o 24 hours after death.

e Funeral Director: After this letely filled in by the funeral di 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation 1 ☐Yes 2 ☐No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

within 2 To the I

the

State

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1221 National Highway, LaVale, MD Shiv C. Khanna, M.D.,

and manner stated.

32. Registrar's Signature 31. Date filed (Month, Day, Year) JAN 0 4 2010

Registrar

29c. License number D0054004 29d. Date signed (Month, Day, Year)

21502

January 4, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Audrey J. BERNARD January 1, 11:25 A M 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Collingswood Nursing Center Rockville Montgomery 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Days Months 169-20-6750 1 □ M 2 🛣 F Hours **Director** 1928 Massachusetts Usual Residence of Decedent permit. Pages 1 and 2 should be filad within 72 hours after death with the Maryland Department of Haalth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it is Modical Exemities man be reserved. 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Montgomery N. Potomac 1 ☐Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
United States 11647 Ranch Lane 20878 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐No if Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. white ģ 3√ Widowed 4 Divorced Specify: Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 <u>Davcare Provider</u> Child Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Dorothy Rubinson ၉ Benjamin Lovett 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11647 Ranch Lane, N. Potomac, MD 20878 Jordana Bernard, Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King David Memorial Gården 01/03/|10 Falls Church, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Torchinsky Hebrew Funeral Home 254 Carroll St., NW, Washington, DC 20012 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours affect death.

To the 74 hours affect death.

To the 7-tuneral Director: Affect this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be deteched for use as the burital-transit Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Year Dav 5 ☐ Other (specify) 9 Unknowh Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 15 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: Certification: To 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 1 X Natural 2 Accident 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation illed in by tha fi 1 ☐ Yes 2 □No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated 29b. Signature and titl 29c. License number 29d. Date signed (Month, Day, Year) 00057574 111/2010 30. Name and address of erson who completed cause of death (Item 23a) (Type, Print) Silver SN My, MD sunt rel 10103 Cenyer ave

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

04

Registrar's Signat

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Bernard Bullock	State of Maryland / Department of Health and Mental Hygiene 1-For State Registrar Certificate of Death Reg No.	01018
Physician/ Medical Examine	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year	3. Time of Death 1009 hrs
	4a. Facility Name (if not institution, give street and number) Southern Maryland Hospital 4b. City, Town, or Location of Death Clinton 4c. County of Death Prince Georg	
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birth (MM/DD/YYYYY) 9. Birth (MM/DD/YYYYYY) 9. Birth (MM/DD/YYYYY) 9. Birth (MM/DD/YYYYYY) 9. Birth (MM/DD/YYYYY) 9. Birth (MM/DD/YYYYYY) 9. Birth (MM/DD/YYYYY) 9. Birth	irthplace (State or ignNorth ounty) Carolina
y, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland calth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f show any traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 X Divorced If Yes, Give Year or Dates: 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Ame White, etc. Specify: 14. Race - Ame White, etc.	rican Indian, Black, ${\tt C}k$
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours afte Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner To Be Completed by	Ulysses Bullock Annie Henderson	e, Zip Code)
Baltimore, N permit. Pages I and Department of Healti Important: If item injury or other trau	20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 Donation Donation Process 21. Signature For Process 22. Name and Address of Facility Ronald Taylorll Forms 4 Home 10583 Middleport Ln White	, Md uneral
Physician Examiner Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	Approximate Interval Between Onset and Death
0, be execut sician and ourial - tra	UNPENDED AMENDED AMENDED AMENDED AMENDED 23d. Date of deliver months? 1	ry Day Year
cords, P.O. aw requires that the has been signed by the should be detached by PPI	1 Yes 2 No 3 Pro 24a Was an autopsy performed? 1 Yes 2 No 1 No 1 Yes 2 No 1	utopsy findings available completion of cause of
Division of Vital Rec spital or Attending Physician: The I rours after death neral Director: After this certificate. filled in by the funeral director, page Certification: To Be Corr	25. Was case referred to medical examiner? 1 Ves 2 No 26. Place of Death (Check only one) 1 Ves 2 No 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred	
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the edical Certificatic		ted
To the How within 24 h To the Fun completely	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the and manner stated. 29b. Signature and title of pertifier 29c. License number 29d. Date signed (Mc) January 5, 2010	onth, Day, Year)
R 10	39. Name and address of person who completed cause of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
State Registrar		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Yola Thomas Booze 4:15 p^M 2010 January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Dorchester Cambridge 1273 Hudson Road If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month) Days | Hours | Min. | June 21, 1949 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Months Maryland 60 Director 216-56-2153 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show 1 ☐ Yes 2 X No traumatic event, the the digal Examiner must be notified Director Cambridge MD Dorchester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or USA 1273 Hudson Road 21613 Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 Yes 2 XNo 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 0 If Yes, Give Year or Dates: 1 ☐Yes 2 No Specify: þ Specify: white 3 Widowed 4 □ Divorced 'natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) health care certified nurses aide permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygic Important: If item 27 is marked other t any injury or other traumatic event, III. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Wilbert C. Booze, Sr. Helen Kimmey 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1403 Stone Boundary Rd., Cambridge, MD N. Ted Booze brother 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Crematory of Delmarva 1/4/10 Delmar, DE 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Thomas Funeral Home P.A. ure of Funeral Service Licensee 700 Locust St., Cambridge, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final cardiomyopathy **Physician** 15 chemic disease or condition resulting in death) /Medical Examiner heart failure congestive cuertially list our ditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Year 5 ☐ Other (specify) □Yes 2□No P.O. signed by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s this certificate 1 □Yes 2 No 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After thi 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Division Hospital or Attending 24 hours after death. 1 Natural 5 Pending 1 ☐Yes 2 ☐No investigation 2 Accident Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft

To the Funeral Di

completely filled in 29a. Certifier 1 Gretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

3

DHMH 17 Rev 1/2001

State Registrar Bramble

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32. Registrar's Signature

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

40059973

Cambridge MD

1/4

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 3^{Day} **Physician** 201⁰6 2:46 A M Dan Albert Bunting, Jr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Atlantic General Hospital Berlin Worcester 8. Date of Birth (Month, Day, Year, 12/28/1953 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Min. Days 1 🕅 M 2 🗆 F Months Hours 56 212-66-2178 MD Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heath and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-1 shov any Injury or other traumatic event, Ilm Medical Examinations and Indianal Examinations are sent than Medical Examinations and Indianal Examinations are sent than Indianal Examinations and Indianal Examinations are sent thandles and Indianal Examinations are sent than Indianal Examinati 1 □Yes 2 X No Director MD Worcester Berlin 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21811 USA 312 Maple Ave. Apt. 20 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specity Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☒ No 14. Race - American Indian, 11. Marital Status 1 Never Married 2 XMarried Baltimore, Maryland 21215-0036 1 ☐Yes 2**X** No If Yes, Give Year or Dates: Specify: þ Specify: white 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Town of Berlin Public Works 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Nora Lee Quillen Dan Albert Bunting, Jr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Ellen Bunting / wife 312 Maple Ave., Apt. 20, Berlin, MD 21811 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State Cape Henlopen Crem. 1/7/2010 Frankford, DE 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funer 22. Name and Address of Facility Burbage Funeral Home Service License 108 William St., Berlin, MD 21811 Approximate Interval Between Onset and Death Part 1. Enter the Mease, ir complications that cous shock, or heart fillure. Let only one cause on pact ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. E. Immediate Cause (Final disease or condition resulting in death) Myocardia Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-transit Due to (or as a consequence of) Box 68760, law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗆 Ectopic pregnancy Year 5 ☐ Other (specify) signed by the a 2 No Division of Vital Records, P.O. 9 Unknown 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>გ</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate 1 ☐ Yes 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Certification: To After this e Hospital or Attending Phy: 124 hours after death. e Funeral Director: After this letely filled in by the funeral di 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check on one and manner stated 29d, Date signed (Month, Day, Year) 29c. License number 29b. Signature a 4,2010 D58755

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DHMH 17 Rev 1/2001

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Registrar

Brive, Berlin

32. Pegistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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JAN 05

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month BIAN 30 M Medical 4a. Facility Name (if not institution, give street and number) Examiner City, Town, or Location of Death of Death 0 99n Mber land 5. Social Security Number If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 218-24-8569 1 **№** M 2 🗆 F Months Davs Hours Min. (Month, Day, Year) 90 Director Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location 72 hours after death with the Maryland 10d. Inside City Limits Director SOMERSET WELLERS BURG 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral um ber kind USA "natural", or items 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian Examiner Armed Forces?

1 Services 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black White etc. Completed by 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: White 3 Widowed 4 Divorced Year or Dates. 42-45 the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) TIRE MANUFACTURE ABORER other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) BLANK should be Charles MARY ALICE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ALFRETTA HWY Wellersburg PA Page 1 and 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State injury or ST PATRICK CEM MT, SAVAGE, 4 ☐ Donation 5 ☐ Other (Specify) 1-6-2010 permit. Signature of Funeral Service Licenses 169 Clarence St 22. Name and Address of Facility HYNOMAN PA 15545 H. Zeigler F.H. INC Harvey 23a. Part 1. Enter the deease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line, Approximate Interval Between Onset and Death Immediate Cause (Final 00 Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a conseque the Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transit and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy for in the past 12 months? Dav Pregnant at time of death Yes 2 No the Unknown detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ g Division of Vital Records, 2 No 3 Probably 4 Unknown Completed 1 Yes has been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No death? To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate is completed filled in by the funeral director, pag 1 ☐ Yes 2√ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ပ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 5 Pending Investigation Could not be 2 Accident 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) SUDHFER JANKORNU 69 201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12500 Willowbrook SE Comberland SUDHEER SANIKOMMU MO 21502 JAN 0 6 2010 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Barclay Washington George JANUARY 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CUMBERLAND ALLEGANY WMHS - REGIONAL MEDICAL CENTER . Social Security Number 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex **Funeral** 1 € M 2 □ F (Month, Day, Year, 06/04/192 Country) Marvland Months Days Hours Min Director 219-14-5601 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 🌠 Yes 2 🗌 No Allegany Lonaconing 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? Funeral 21539 USA 15 Water Cliff Street Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. Ş 1 Never Married 2 X Married 1943-1 ☐ Yes 2 🔀 No Specify: White 3 Widowed 4 Divorced Completed 1946 Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Paper Mill Guard Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) <u>0</u> Barclay Veronica Garlitz Alexander 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15 Water Cliff Street, Lonaconing, MD Ruby M. barclay / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State Cumberland Crematory | 01/07/2010 Cumberland, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Adams Family Funeral Home, Signature of Funeral Service Lice 404 Decatur Street, Cumberland, MD 21502 23a. Part 1. Soler the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner monasy or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ ate has been signed by the atte page 2 should be detached for a in the past 12 months?
1 ☐ Yes 2 ☐ No Year Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Wunknown Certificate: To Be Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate 1 🗌 Yes 20K No 1 ☐ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 2 No 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Hospital c

BUA

31. Date filed (Month, Day, Year) State Registrar

ENKESHAFI, ARDALAN, M.D., 12500 WILLOWBROOK ROAD, CUMBERLAND, MD 21502 32. Registrar's Signature

30. Name and address of person who completed cause of death (leen 23a) (Type, Print)

Medical

29a. Certifier

Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, usual occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D68455

01,06,2010

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 4 Day **Physician** 2010 8:43 P M Joan Eleanor Broschard /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 13 Ebb Tide Ct. Berlin Worcester 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 4/1/1933 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 🕱 F 76 NY Director 128-26-2541 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 28a-f show other traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 No Berlin MD Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or 13 Ebb Tide Ct. 21311 USA Funeral permit. Pages 1 and 2 should be filed within 72 hours after death. Dispartment of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s any injury or other traumatic event. the Martiral Exercises. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2X No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced white Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert Johnson Dorothy Loeble ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Broschard / husband 13 Ebb Tide Cr., Berlin, MD 21811 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 1/5/2010 Frankford, DE 4 ☐ Donation 5 ☐ Other (Specify) Cape Henlopen Crem. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Burbage Funeral Home Bor. 108 William St., Berlin, MD 21811 23a. Part1. Eyer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, / heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Approximate interval Between Onset and Death **Physician** wall /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detanhed for use as the harmal than the funeral director, page 2 should be detanhed for use as the harmal than the funeral director. Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4 Pregnant at time of death 5 Other (specify) 9 Unknowf 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, \$ 2 No 1 ☐ Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐Yes 2 ☐No 1 ☐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ inpatient 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

BAIR

State Registrar

Registrar JAN 0 6

31. Date filed (Month, Day,

32. Ragistrar's Signature

32. Ragistrar's Signature

B. Janks

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

elle

Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) JANUARY 2 Day 2010 **Physician** 1:20 P M BURNS JR. FRANCIS J. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner HYATTSVILLE 8. Date of Birth
(Month, Day, Year) PRINCE GEORGE'S ST. THOMAS NURSING HOME If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex **Funeral** Min. Hours Months Days 1929 NEW YORK 1 XM 2 □ F 80 Director 126-20-7857 Usual Residence of Decedent death with the Maryland 10c City Town or Location 10d. Inside City Limits 10a. State r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Directo SPOTSYLVANIA FREDERICKSBURG VA 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 22407 10009 PEPPERMILL COURT Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 X Married WHITE 1 ☐ Yes 21 No Maryland 21215-0036 Specify Specify: <u>م</u> 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) COVERNMENT C.P.A. 4+ other 1 traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy Important: If Item 27 Is marked other any injury or other traumatic event, 17. Father's Name (First, Middle, Last) Be MCNAMARA MARY CECILIA FRANCIS J. BURNS 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 10009 PEPPERMILL COURT FREDERICKSBURG, VIRGINIA 22407 CLAUDETTE DEHAIS BURNS/WIFE Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/28/10 ARLINGTON, VIRGINIA ARLINGTON CEMETERY 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ODONAN disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner MITERIOSCOP Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner be executed burial-tran Due to (or as a consequence of) Box 68760, physician Physician/Medical requires that the death certificate the as IF FFMALE nse 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year for in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 1 ☐ Yes 2 ☐ No P.O. 9☐Unknown 9 Tunknown 23e. Did tobacco use contribute to the cause of death? signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause givening Part I. Records, þ 10 Went | Yes Unknown 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☒ No 24a. Was an law autopsy performed? Yes 2 No has page 2 The ornina certificate 1□ Yes Division or Vital Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P 27. Manner of Death 1 Natural 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Certification: (Month, Day Year) Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident d in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined after 4 Homicide within 24 hours a To the Funeral I completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Day, Year) State 0 5 2010 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January Day 2010 Year Blankenship 1 2:00 A Edna Irene Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's 9115 Marlboro Pike Upper Marlboro Social Security Number If Under 1 Year I If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign **Funeral** 1 M 2 X-XF Months Days $\int_{\mathbf{u}}^{M_{\mathbf{v}}} \mathbf{v}^{th}, 2\mathbf{s}^{y}$ T954 Washington, DC 212-66-4746 55 **Director** Usual Residence of Decedent 23a or 28a-f shov 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 ☐ Yes 2XX No Maryland Upper Marlboro Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral #23 USA 9115 Marlboro Pike 20772 or items within 72 hours after death Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. Black, White etc. ģ 1 Never Married 2XX Married 1 ☐ Yes If Yes, Give 2xx No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", Completed 3 Widowed 4 Divorced White Year or Dates. the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12 years College (1-4 or 5+) Sales Food Service Industry other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည James Benjamin Frick Lois Mae Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harold E. Blankenship Sr./ Husband 9115 Marlboro Pike #23 Upper Marlboro, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 XX Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cemetery 01/06/2010 4 ☐ Donation 5 ☐ Other (Specify) Suitland, Maryland any injury 21. Signature of Funeral Service Licens 22. Name and Address of Facility George P. Kalas Funeral Home P.A. als 6160 Oxon Hill Road Oxon Hill, Maryland 18 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause in each line Immediate Cause (Final Physicians disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury or Attending Physician: The law requires that the death certificate be executed sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy Month Year Pregnant at time of death ed by the a 9 Unknown P.O. s been signed to should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 Tyes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s has autopsy pertorme death? certificate 1 ☐ Yes 2 ☐ No Yes director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Other: 4 \(\text{Nursing Home} \) 5 \(\text{M} \) Residence \(6 \) Other (Specify) 1 Yes 2 1 No ည 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Man er of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After (Month, Day, Year) Natural 5 Pending work? To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu death. 1 Yes 2 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date sid ZOID 30. Name and address of person who pleted cause of death (Item 23a) (Type, Print) filed (Month, Day, Year) State JAN 0 5 2010

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) JOHN R, BURNS, SR. JARUARY DAY **Physician** 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Randallstown Baltimore Northwest Hospital Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12/29/1936 Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours 1 X M 2 □ F 73 MD 213-34-4176 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State pes 1 and 2 should be filed within 72 hours after death with the Marylan t of Health and Mental Hygiene. If item 27 Is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Evamine 1 ☐ Yes 2 XNo Funeral Director Marriottsville MD Howard 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21104 United States 11468 Old Frederick Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1958-1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1960 1 ☐Yes 2 ☑ No Specify: Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Real Estate <u>Real Estate Appraiser</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ၉ Luke K. Burns, Sr. Mary Jane Reed 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 11468 Old Frederick Road Marriottsville, MD 21104 permit. Pages 1 and Department of Health Important: If item 27 any injury or other th Once. Lucy Burns - wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 11 Burial 2 ☐ Cremation 3 ☐ Removal from State 1/9/2010 Crestlawn Marriottsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family F.H.Inc. 4112 Old Columbia Pike Ellicott City, MD 21043 21. Signature of Funeral Service Licensee M00845 more f. · Cma 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. NTRICULAR Immediate Cause (Final TACHYCARDIA **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner HYPERKALEMIA if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner F AILURE RENAL 17 CUTE and -trans Due to (or as a consequence of): burialphysician s the burial Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by PANCREATIC CARCINOMA 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown been si should t 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l autopsy performed? Yes 2 No certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 npatient 1∐Yes 2 No 2 ER/Outpatient 3 DOA this Certification: To After thi funeral of Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Natural 2 Accident 5 Pending n 24 hours after death.

le Funeral Director: Aft
bletely filled in by the fur 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760, P.O. Records, Division of Vital

Baltimore, Maryland 21215-0036

within 2 5+1

Registrar

DHMH 17 Rev 1/2001

Medical

29a. Certifier (Check only one)

29b. Signature and

of certifie HYSICIAN

and manner stated

29d. Date signed (Month, Day, Year) JANUARY 04

NORTHWEST HOSPI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VERAHALLI 401

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2010^{Year} Day Physician/ 12:15A M Barham January Evelyn Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George Oxon Hill 4727 Summertime Drive If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours April 3, 224-20-9224 1 M 2 XXF 84 Virginia Director Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f shor 10a. State 10b. County 10c. City, Town or Location Director 1 X Yes 2 No New York Jamaica Queens 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Funeral 11433 107-02 Merrick Blvd #6M 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 🔀 No Specify: 3 X Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Medica1 Domestic 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Mary Dellinger Phillip Dozier 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4727 Summertime Drive Oxon Hill, Md. 20745 Muriel L. Whitfield/Great Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 KRemoval from State Calverton Nat'l Cem. 1/5/2010 Calverton, New York 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signatura f Funeral Service Licensee George P. Kalas Funeral Home P.A. 6160 Oxon Hill Road Oxon Hill, Maryland alos 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one-cause on each line. Interval Between Onset and Death shock, or heart failure. List only one Immediate Cause (Final Physician 0 Medical resulting in death) Due to (or as a consequence of) Examine Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 menths?
1 Yes 2 No Month Day Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a Was an ours after death.

leral Director: After this certificate has I filled in by the funeral director, page 2 s prior to completion of cause of death? autopsy 1 Yes 2 No 25. Was case referred to medical exampler?

1 Yes 2 No 26. Place of Death (Check only one) Be Niece's Other: 4 \(\square\) Nursing Home \(5 \square\) Residence ပ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 5 Pending 1 Natural 1 🗌 Yes 2 🗌 No Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) To the Hospital within 24 hours a To the Funeral C completed filled in the filled in t Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated
3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 69

State Registrar Barry Redjaee, M.D. 4467 Old Branch Ave. #201 Temple Hills, MD. 20748

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)
JAN 0 5 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#19a, b, perFH#29d, perDVR, G899, 1719, 2010, WS

State of Maryland / Department of Health and Mental Hygiene 20 | 0 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 3 Physician/ Month Year. Kenneth William Barnhart, Jr. 2010 5.45 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Washington County Hospital Hagerstown 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Hagerstown, MD 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1**★** M 2 □ F Days Hours 01 08 214-42-1087 Director 65 Usual Residence of Decedent show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** ems 23a or 28a-f sh r must be notified a Washington Clear Spring 1 ☐ Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12053 Big Pool Road 21722 US items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 24 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ò Completed by 1 Never Married 2 X Married 1 Yes If Yes, Give white 1 Yes 2 No Specify Specify: "natural" 3 Widowed 4 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) l Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the machinist truck company Ith and Mental Hygie 27 is marked other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Kenneth W. Barnhart, Sr. Anna Mary Daley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kelli Ann Leidig/daughter Linda Mae Barnhart/ Spouse Health a 12053 Big Pool Road Clear Spring, MD 225722 27 item 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition jo 1 🛛 Burial 2 🗆 Cremation 3 🗀 Removal from State ± 5 Department or Important: If any injury or once, Greencastle, PA Pleasant U.B. Church | 01/09/2010 | 4 ☐ Donation _5 ☐ Other (Specify) 21. Signature of Luneral Service Lice 22. Name and Address of Facility Miller-Bowersox Funeral Home 521 S. Washington St. Greencastle, PA Approximate 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of: Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death ate has been signed by the page 2 should be detached 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Ves 2 No 3 Probably 4 Unknown Were autopsy findings available 24a. Was an prior to completion of cause of death?

1 Yes 2 No certificate has 3 NM Yes 2 No 25. Was case referred to medical examiner? funeral director, 26. Pla of Death (Check only one) Hospital 2 D No Other: မြ 1 Tes 1 Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending after death. 2 Accident
3 Suicide
4 Homicide M Investigation the Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined filled in within 24 hours a **To the Funeral D**completed filled i Medical 29a. Certifier 1 🖵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 11111 Date filed (Month, Day, Year) 32. Registrar's Signature 21747 Registrar

3altimore, Maryland 21215-0036

Records, P.O. Box 68760

Division of Vital

Physician /Medical

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	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Diractor: After this certifical completely filled in by the funeral director,		29a. Certifier	1 Certifying Ph	ysician: To the	he best o	of my knowledge	, death occurre	d at the tir	ne, date and pla	ce, and due to th	e cause(s) and mann	er as stated.	e(s)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar AMEND#20bperrFH, 1-8-10, BMW, McCo Certificate of Death Reg. No. Decedent's Name (First, Middle, Last, 2. Date of Death Physician/ ^{Day} 2010 9:20 a January 1, Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park Mon top mery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye June 2, 19 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, **Funeral** Days 163-24-1913 1 🗆 M 2 🖼 F 79 Hours Min. Yrs Director New Jersey Usual Residence of Deceden 28a-f shov 10b. County 10a, State filed within 72 hours after death with the Maryland the Medical Examiner must be notified at Director 10c. City, Town or Location 10d. Inside City Limits Maryland Mon topmery Silver Spring 1 Yes 2 No ō 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral or items 23a 2600 Arvin Street 20902 TISA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 "natural", 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 Is marked other than ' Elementary/Seconday (0-12) College (3-4 or 5+) Administrative Assistant Federal Government traumatic event. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ည Cosmos Cotrona Antonia Berenato 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2000 Franwall Avenue, Silver Spring, MD 20902 Robert G. Cunningham/Son other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of Important: If it any injury or o Jan. MD Veterans Cemetery 1 A Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2010 Cheltenham, Maryland Francis J. Coliffie Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 21. Signature of Funeral Service Licenses KleC May 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to for as a consequence of Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 호 Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 N No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Director: After this in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural 5 Pending Accident Investigation filled in by the 3 Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ddress of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

4

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Solomon Colker 2010 January 11:05A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery 3118 Gracefield Road Silver Spring 5. Social Security Numbe If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Min. July I, 1918 262-26-7378 Months Days Hours Pennsylvania Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 🗆 Yes 2 🖁 No Silver Spring Maryland Montgomery 10e. Street and Number 10g. Citizen of What Country? United States of America 10f. Zip Code Funeral 20904 3118 Gracefield Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, ō Armed Forces Completed by 1 Never Married 2 X Married 1 1 Yes 2 □ No If Yes, Give 1 Maryland 21215-0036 Specify: Caucasian 1 ☐ Yes 2 X No Specify: "natural". 3 Widowed 4 Divorced Year or Dates. permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any Injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Transportation Economist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Fanny Snyder Harry Colker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 338 Los Alamos Road, Santa Rosa, CA 95409 Frances Danoff, Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 K Burial 2 ☐ Cremation 3 ☐ Removal from State Judean Memorial Gardens Olney, Maryland 01/03/201b 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityHines-Rinaldi Funeral Home, Inc. Whe 11800 New Hampshire Ave, Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death BRO VASCUL Physician disease or condition resulting in death) Medical Due to (or as a consequence of) EARS Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence on and -tran that the death certificate be exect Due to (or as a consequence of) resulting in death) Last sate has been signed by the attending physician a page 2 should be detached for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death g Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Hospital or Attending Physician: The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed certificate 1 🗌 Yes 2 🗌 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 M No ပ 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer. (Month, Day, Year) 1 Matural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 3 ☐ Suiciae 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, 84 2010 5+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KORZAN FIELD

State

Registrar

31. Date filed (Month, Day, Year)

JAN 04

82. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 01030 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JANUARY 2010 3:27 A M COVINGTON Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PRINCE GEORGE'S PRINCE GEORGE'S HOSPITAL CHEVERLY If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 8. Date of Birth 7. Age (In yrs. last birthday) Funeral 6. Sex 1 - M 2 X F Months Hours DECEMBER 7 NORTH CAROLINA Director 240-60-1378 70 Usual Residence of Deceden "natural", or items 23a or 28a-f show edical Examiner must be notified at ould be filed within 72 hours after death with the Maryland nd Mental Hygiene, marked other than "natural", or items 23a or 28a-f sho matic event, the Medical Examiner must be notified at 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location Director 1 X Yes 2 No PRINCE GEORGE'S CAPITOL HEIGHTS MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 18 MARYLAND PARK DRIVE 20743 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 🛣 No If Yes, Give Black, White, etc. 1 Never Married 2 XMarried þ Specify: BLACK Maryland 21215-0036 1 Yes 2X No Specify: 3 Divorced Completed Year or Dates. 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) DATA PROCESSING PRIVATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be filed tment of Health and Mental H rant: If item 27 is marked ot မ MARTHA PATTERSON EARLIE WILLIAMS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20743 BELTON COVINGTON JR/HUSBAND 18 MARYLAND PARK DRIVE CAPITOL HEIGHTS, MARYLAND permit. Page 1 and 2 Department of Healt Important: If item 2 Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of 1 🔀 Burial 2 □ Cremation 3 □ Removal from State injury or INCOLN CEMETERY 1-09-2010 SUITLAND, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility JB JENKINS FUNERAL HOME 21. Signature of Funeral Service Licenses 7474 LANDOVER RD LANDOVER, MD 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between 30 minutes Immediate Cause (Final MYOCARDIAL INFARCTION Pnysician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of): Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury ysician and e burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 phy attending p use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death 1 Yes 2 No signed by the a d be detached f 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by HYPERTENSION 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? HYPERLIPIDEMIA 24a. Was an cate has page 2 s autopsy performed? 1 Yes 2 No certificate 1 Yes 2X No Division of Vital 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 X No ဂ္ 1 Inpatient 2 🔀 ER/Outpatient 3 🗆 DOA after death.

Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 XNatural 5 Pending 2 Accident
3 Suicide Investigation completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined 24 hours Medical 🖄 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

☐ Certifying Nurse_Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29d. Date signed (Month, Day, Year) 29b. Signature and title of co 29c. License number 1-4-2010 D47603

CR 3

State 31. Date filed (Month, Day, Year)
Registrar JAN 0.6.2010

32. Registrar's Signature

who completed cause of death (Item 23a) (Type, Print)

WILLIAM DUBOYCE M.D. 12158 CENTRAL AVENUE MITCHELLVILLE, MARYLAND

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? 0103 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year ar Penter Sv houar 1413 bert 010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Memorial Hospital Talbot Easton If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 □ F (Month, Day, Year Months Days Hours Director Marylano Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Completed by Funeral Director 10d. Inside City Limits 1 🗹 Yes 2 🗆 No Talbo 10e. Street and Number 10g. Citizen of What Country? nnery 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: If Yes, Give Year or Dates Black Specify: 3 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and 2 should be filed within 72 | Department of Health and Mental Hygiers Inportant: If item 27 is marked other than any injury or other traumatic event. the Me Elementary/Seconday (0-12) College (1-4 or 5+) onst 10 Be Maryland 17. Father's Name (First, Middle, Last) မ Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Seraldine MD.21657 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 12010 4 ☐ Donation 5 ☐ Other (Specify) enetery 21. Signature of Funeral Service Licenses 22. Name and Address of Facility HOME, P. A. Funeral 23a. Part I. Enter the disease, or complications that caused the eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Hemorrhagic
Due to (or as a consequence f): Physician/ disease or condition Medical resulting in death) Examiner castro intestina Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed igned by the attending physician and be detached for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Chronic 1 KYes 2 □ No 3 □ Probably 4 □ Unknown Were autopsy findings available pnor to completion of cause of 24a. Was an has autopsy death? After this certificate Yes 2 No 1 Yes 2 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 No Other: Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident 3 Suicide
4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title 29d. Date signed (Month, Day, Year) 1-4-2010 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Easton, MD ZIGOI Washington St 31. Date filed (Month State JAN 06 Registrar

For Amend#31 per Avon State of Maryland / Department of Health and Mental Hygiene State Registrar 1/4/2010 OMH Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2010^{Year} Physician/ Joyce Carpenter Peggy January 1 12:00 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Crofton 1433 Crofton Parkway 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** October 10,1931 Months Days Hours Min. West Virgini 78 Director 216–28–9783 Usual Residence of Decedent items 23a or 28a-f show ier must be notified at 10d. Inside City Limits 10a, State 10b. County 10c. City. Town or Location be filed within 72 hours after death with the Maryland Director Crofton MD Anne Arundel 1 Yes 2 No 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? USA 1433 Crofton Pkwy 21114 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces? ian "natural", or iter Medical Examiner Black, White, etc. ٥ 1 Never Married 2 Married 1 Yes 2 XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛂 No Specify: If Yes, Give Year or Dates White 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) 12 College (1-4 or 5+) 4 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental F is marked o ဂ္ Harry Fulford Veda Kennedy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra 806 Hedgehopper Lane, Gambrills, MD 21054 Leslee Brady/Daughter 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place, 01/06/2010 4 Donation 5 Other (Specify) Baltimore, Maryland Bavview Crematory 21. Signature of Funeral Service Licensee Beall Funeral Home 22. Name and Address of Facility 6512 NW Crain Hwy., Bowie, MD 20715 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Menos Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) and I-transit Exami that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical that the death certificate be 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Box 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☑ No Pregnant at time of death 1 Yes 2 Le 9 Unknown signed by the a d be detached f g Unknown P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 Yes 2 No 3 Probably 4 Unknown Records, cate has been sig , page 2 should b Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed Yes 2 No death? 1 Yes 2 No certificate Hospital or Attending Physician: Division of Vital 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Hospital: Other: No use ...

Vithin 24 hours after opea...

To the Funeral Director: After this c မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d, Describe how injury occurred Certificate: 1 Matural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide
4 Homicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practional: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 2010 who completed cause of death (Item 23a) (Type, Print) M 32. Registrar's Signature State Registrar

Physician /Medica Examine Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any lojury or other traumatic event, the Medical Evaminar must be retified at once.

Baltimore, Maryland 21215-0036

Physician /Medical **Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

15 MRS

	for State Registrar	State o	of Maryland	-		of Health of Death		_	giene 0	10	01033		
	1. Decedent's Name (First, Middle	, Last)						2. Date of De	ath		3. Time of Death		
n	Francis Xavier Cos	sgrove						Month Janu	Day 1 217 06, 201	Year 10	11:50 AM M		
al er	4a. Facility Name (If not institution		ımber)		4b. City, To	wn, or Location	of Death		1 '	ty of Death			
	170 Mount Pleasant	Street				Frostl	oure		Alleg	any			
		6. Sex	7. Age (In yrs. I	ast birthday)	If Under 1	Year If Unde	r 24 Hrs.	8. Date of Bir (Month, Da	_	9. Birth	place (State or Foreign		
	216-22-7328	1)≰ 1 M 2□ F	83	Yrs.	Months [Days Hours	Min.	March	19, rear) 103, 1926		yland		
	Usual Residence of Decedent		0.5				1			17100	7 10210		
	10a. State 10b. County		10c. City	, Town or Lo	cation						10d. Inside City Limits		
ģ	Maryland Alle	gany	Fro	stburg							1 Maryes 2 □ No		
ĕ	40- 01111	ount Pleasa	nt Ctuant		10f. Zip C	ode			10g. Citizen of	f What Cou	intry?		
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ě	11. Marital Status	12. Was Dec	edent Ever in U.S	6. 13. V	Vas Deceder	nt of Hispanic O	rigin? (Sp	ecify Yes or No		ace - Amer	ican Indian,		
Completed by Funeral Director	1 ☐ Never Married 2 ☐ Marri	Armed Fo	orces?	l l	f Yes, specify	Cuban, Mexica	ın, Puerto	Rican, etc.)		ack, White,	etc.		
Š	3 ☑ Widowed 4 ☐ Divorced	If Vers G		77 1	I∐Yes 2	¶No Specify	<i>'</i> :		Spec		4.		
ed	15. Decedent				dent's Usual (Decupation			16b. Kind of I	Whi Business/Ir			
<u>p</u>	(Specify only highes	t grade completed)		(Give life. L	kind of work o OO NOT use	done during mo retired)	st of work	ing			·		
E	Elementary/Secondary (0-12)	College (1-4or 5+)	owner	/operato	r			liquor st	tore			
ت	17. Father's Name (First, Middle, L	.ast)			. op		er's Name	e (First, Middle	_				
De C	George L. Cosgrove	,						evinsky					
0	19a. Informant's Name/Relationsh			10h M-99-	n Addres - "				or City or To	n Ctat- 7	in Cada)		
			tor			Street and Numb					2.1539-		
	Mary Ann Jenkins 20a. Method of Disposition	daugh		ace of Dispos		ountain Rd		aconing Date	20c. Location	yland			
	1 Burial 2 ☐ Cremation	3 Removal from		emetery, cren	natory or othe	er place)	'	Date	200. Location	1 - Oily Oi 1	Own, State		
	4 ☐ Donation 5 ☐ Other (Sp	ecify)	S	aint Mich				ry 09, 2010	Frostbur	g N	Maryland		
	21. Signature of Funeral Service L	icensee	1			Address of Facil	•		5 4	1.00			
	John To	Klur.	J			meral Horr				5, MD 1	21532		
	23a. P. M. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart fallure. List only one cause on each line. In mediate Cause (Final disease or condition a A A A A A A A A A A A A										Approximate Interval Between Onset and Death		
	rescuing in death)	resulting in death) Due to (or as a consequence of):											
e	Sequentially list conditions, Due to lor as a consequence of the sequence of												
	Sequentially list conditions, if any, he dog to immediate cause. Enter Underlying Cause (Disease or injury												
X	that initiated events resulting in death) Last	c Due to	(or as a consequ	ence of):									
dical Examiner													
		d						-		_			
ME	IF FEMALE:	23c. If yes, ou	tcome of pregnar	ncv					004 0)			
ā	23b. Was decedent pregnant in the past 12 months?	1 Live	birth 2 Fetal	death 3	Ectopic pre					ate of deliv Month	very Day Year		
yer	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		4 ☐ Pregnant at time of death 5 ☐ Other (specify)										
Ξ	Part II. Other significant condition	ns contributing to d	eath but not resu	lting in the un	derlying caus	se given in Part	I.	23e, Did t	obacco use co	ntribute to	the cause of death?		
Completed by Physician/Infe					,	g.,		1□	/	/	bbably 4 🗆 Unknown		
100									100				
₹.								24a. Was auto	osy	prior to co	opsy findings available ompletion of cause of		
5								perfo	rmed? 2 No	death? 1 □ Yes	2 🗆 No		
200	25. Was case referred to medical examiner?					26. Plac	e of Deat	h (Check only o					
	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1	Inpatient 2 🗆 l	ER/Outpatien	t 3 DOA	Other: 4 🗆 N	lursing Ho	ome 5 🗷 Resi	dence 6 🗆 O	ther (Spec	eify)		
:	27. Manner of Death	28a. Date	of Injury oth, Day, Year)	28b. Time of Injury	28c	. Injury at Work?		28d. Describe	how injury occu	irred			
	1 Natural 5 Pending 2 Accident investig		, 20,, 1001)	yory	М	1 ☐ Yes 2 ☐]No						
2	3 ☐ Suicide 6 ☐ Could not determine	200. Flact	of Injury - At hor	me, farm, stre	et, factory, o	ffice		28f. Location (Street and Nun	nber or Rui	ral Route Number,		
	4 nonlicide	Dulid	ing, etc." (Specify	,				City or To	wn, sate)				
Medical Cel tilication. 10	29a. Certifier 1 Certifying (Check only one)	g Physician: To the examiner: On the band man	e best of my know basis of examinat aner stated.	vledge, death ion and/or inv	occurred at vestigation, ir	the time, date an my opinion, de	and place, ath occur	and due to the red at the time,	cause(s) and i	manner as e, and due	stated. to the cause(s)		
2	29b. Signature and title of certifier	1,11			29c. L	icense number			29d. Date sign	ned (Month	, Day, Year)		
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		//	se of death (Item	23a) (Type, F	Print)	leish I	0	Com	hereian	W.	mD2150;		
	31. Date filed (Month, Day, Year)	MERL B2. F	Registrar's Signat	ure /	p LUI	عد الردائ	1	COIL	BURE CALL	11	,,,=0,,0=3		
	JAN 0 7 2	J10 Jens	Registrar's Signat	As and	The state of the s								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 7:30A 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2^{Day}2010 Physician/ J. Calhoun Phyllis 1 January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George 812 Crawford Street Oxon Hill If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 🗆 M 2 🔼 F March 21, 1927 Washington, DC 82 578-30-4510 **Director** Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 🗌 Yes 2 🛣 No Oxon Hill Prince George Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Funeral 20745 812 Crawford Street Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Completed 3 X Widowed 4 Divorced permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) 10 College (1-4 or 5+) Giant Food Meat Wrapper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Ε. Clemmons Margaret L. Elton King 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4908 Megan Dr. Clinton, MD. 20735 Paulette A. Gannon/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 1/12/2010 Cheltenham, Maryland MD. Veterans Cemetery 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home alu 6160 Oxon Hill Rd. Oxon Hill, MD. 20745 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 0 months disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Exam To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 X No Day Month Year g Unknown Division of Vital Records, P.O. Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 N 2 No 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other Specify 1 ☐ Yes 2 🗶 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 1 🕅 Natural 5 Pending 1 Yes 2 No Accident Suicide Investigation Could not be 6 🗀 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 6

State Registrar 30_Name and address of p

31. Date filed (Month, Day, Year)

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con who completed cause of death (Item 23a) (Type, Print)

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State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month wary M Jaime Caparas Μ. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince Georges Lanham Doctors Community Hospital . Social Security Numbe If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** Months Hours Min. 1 XM 2 □ F 568-59-0440 65 944 Director Usual Residence of Decedent rat", or items 23a or 28a-f show Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Prince Georges Lanham 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 20706 U.S.A. 6729 Lamont Dr. 72 hours after death . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces 1 Never Married 2 Married ò ☐ Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Filipino permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates other traumatic event, the Medical 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Rephardt & Company <u> Architect Designer</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Guillermo Caparas, Sr. Consuelo Malamba 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6729 Lamont Dr. Lanham, MD 20706 Victoria Caparas (Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ▼ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) any injury or Mount Olivet Cemetery 1/9/10 Washington, DC Pineral Service Licensee 21. Signature 22. Name and Address of Facility Rendon/Hale Funeral Home 9013 Annapolis Rd. Lanham, MD 20706 Tart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart sailure. List only one cause on each list. Approximate Interval Between bral Heriden Onset and Death Immediate Cause (Final Pnysician/ disease or condition resulting in death) Medical Due to (or ag **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine requires that the death certificate be executed and burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Physician/ 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death ed by the a 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed to 23e. Did tobacco use contribute to the car se of death? by 3 Probably 4 Unknown Completed 1 Yes 2 No been sig 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed Yes 2 certificate 1 🗌 Yes 2 🗆 No Hospital or Attending Physician: funeral director, 25. Was case referred to edical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 Yes 2 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Mann f Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After to completed filled in by the funeral Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Effectifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Monty, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Mem 28a) (Type, Print) LANHAM MD 20706 ANNAPOLIS KOAD SUITE 210 OLEG 5HPAK M.D 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 0 5 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		State of Market State of Market State of Market State Registrar 1. Decedent's Name (First, Middle, Last)	aryland / Depa <i>Cei</i>	artment of I rtificate of			Reg.	$ \angle$ \cup	10	0 1 0 3 6	
Physicia /Medic Examin	al er	Henry Cook III Aa. Facility Name (If not institution, give street and number) Look About Manor		4b. City, Town,	or Location of	01 ^{Mo}	inth	4c. County	Year 2010 y of Death	6:15 ^M	
Funeral Director			e (In yrs. last birthday) 87 Yrs.	If Under 1 Year Months Days	If Under 2	Min. 8. Dat	te of Birth onth, Day, Ye 2-02-1		9. Birthp Coun	ace (State or Foreig try) Jersey	
filed within 72 hours after death with the Maryland Yayane Hier than *natural*, or itema 23a or 28a-1 show wit, the Madical Examinar must be notitied at)irector	10a. State 10b. County PA Franklin 10e. Street and Number	10c. City, Town or Lo Chambers	sburg		, -			What Coun	0d. Inside City Limits 1 ☐ Yes 2 ☐ No try?	
irs after death wi	by Funeral Director	1534 Springside Drive Ea 11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Armed Forces? X☒ Yes 2 □ If Yes, Give Year or Dates:	Ever in U.S. 13.	Was Decedent of If Yes, specify Cut	Hispanic Orig ban, Mexican,	in? (Specify Ye Puerto Rican,		Bla	ce - Americ ick, White, fy: Whi	etc.	
d within 72 hou giene. er then "neture. the Medical E.	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 2)	(Give	dent's Usual Occu kind of work done DO NOT use retire	during most	of working	g Communica			,	
nould be file I Mental Hy narkad othe natic event	To Be (17. Father's Name (First, Middle, Last) Henry Cook II 19a. Informant's Name/Relationship (Type, Print)	a- Addrnos /Stron	lla All	en	faiden Sumame) City or Town, State, Zip Code)					
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene and Contractural if them 271s marked other than "natural", or thema 23a or 28a-1 show any injury or other traumatic event, the Madical Examinar must be notified at once.		Delores Cook (wife 20a. Method of Disposition 1 □ Burial 2 🖾 Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Lips (see	20b. Place of Dispo cemetery, crea Thomas L.	Springs: osition (Name of matory or other pla	ide Dr	ive, E. Date 01-13-2 Thomas	Chan 2010 Cl L. Ge	nbersh c.Location hambe eisel	ours, - City or To rsbur Funer	PA 17202 wn, State g, PA. 17	
auth certificate be executed attending physician and attending physician and for use as the burial-transit	Physician/Medical Examiner	Sa: Lantially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	the death. Do not en		ing, such as	cardiac or respi	ratory arrest			Approximate Interval Between Onse and Death Clays	
0 0		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal death 3	□Ectopic pregnan □ Other (specify)	су				ate of delive	ery Day Year	
quires that if in signed by uld be detac	by	Part II. Other significant conditions contributing to death t		3e. Did tobac	ne cause of death? pably 4 Unknow						
: The law requires that the cate has been signed by th page 2 should be detache	Completed			24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No			mpletion of cause o				
To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Certification; To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpati 27. Manner of Death 12 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined 4 Homicide 28e. Place of Input (Month, Del	escribe how	Residence 6 Other (Specify) Lucy Facribe how injury occurred							
To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the I	Medical Cert	29a. Certifier (Check only one) 1 Certifying Physician: To the best 2 Medical Examiner: On the basis and manner si	of my knowledge, deal			d place, and du	ie to the cau	se(s) and n			
To the within 2 To the Comple	Mec	29b. Signature and title of certifier W W W W W W W W W W W W W W W W W W W	to my	Print)	nse number	43		ji .	ed (Month,	Day, Year) 10 21157	
Sta Registr		John w. mildleten 1	death (Item 23a) (Type) C S S rar's Signature	Pode 1	Rd, V	Veston	ninst	Lery	MI	> 2113	

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #8 per Fh 9900 2/18/10 TT State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month January 11:59 PM COOK VIRGINIA Τ, Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Frederick Memorial Hospital Frederick If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9, Birthplace (State or Foreign _{r)}1926 **Funeral** 1 □ M 2 🕱 F Months Davs Hours Min. (Month, Day, Country) 83 **Director** 213-24-9046 Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Frederick Frederick 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21701 USA 529 West Patrick Street Apt1 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. þ 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 10 Own Home Home maker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Theresa V. Trail Russell C. Kidd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 529 West Patrick Street Frederick, MD 21701 Calvin Cook Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State Clustered Spires Cm 1-18-2010 4 Donation 5 Other (Specify) Frederick, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Keeney & Basford P.A. F.H. 106 East Church Street Frederick, MD 21701 M01176 23a. Part Lenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Sepsis Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, rany, leading to immediate cause. Enter Underlying Cause (Disease or linjury that the death certificate be executed and -tran: that initiated events Due to (or as a consequence of) resulting in death) Last physician a the burial-1 Physician/Medical Division of Vital Records, P.O. Box 68760 as 1 attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 ☐ Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by To the Hospital or Attending Physician: The law requires 2 No 1 Yes 3 Probably 4 Unknown been significant 24b. Were autopsy findings available prior to completion of cause of 24a. Was an ate has b page 2 s autopsy perform death? After this certificate I 1 Yes 2 No Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No ၉ MInpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral or 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 \square Pending 1 🔲 Yes 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MDD 69430

Registrar
DHMH 17 Rev 7/2009

State

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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JAN 20 2010

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31. Date filed (Month, Day, Year)

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Frederick

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** JAN.7,2010 ELMER KENNETH COOMBS 5:45A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8530 ROBEY MANOR DRIVE WHITE PLAINS CHARLES If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Pay, 1 Year 3 3 9. Birthplace (State or Foreign MD • 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min 1 XM 2 ☐ F 218-24-7117 76 Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ral", or items 23a or 28a-f shov WHITE PLAINS MD. CHARLES 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8530 ROBEY MANOR DRIVE 20695 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. hours after 1 ☐ Never Married 2 X Married þ 1 □Yes 2 □XNo Specify:WHITE 3 Widowed 4 Divorced is marked other than "natural", aumatic event, the Madical Extra Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry within 72 (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) A&P FOOD STORES CLERK 9th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be f and Mental Η permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev MARY DOROTHY WELCH WALTER ELMER COOMBS ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O.BOX 146 POMFRET, MD. 20675 DORIS COOMBS-SPOUSE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ST. JOSEPH'S CEM. 1-13-2010 POMFRET, MD. 22. Name and Address of Facility
RAYMOND FUNERAL SERVICE, P.A.
LA PLATA, MD. 20646 M00479 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ancel **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) The law requires that the death certificate be execute attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) 1 □Yes 2 □ No. the 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Tyes 2 No 3 Probably 4 Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t page 2 s autopsy perform certificate 1 ☐Yes 2 No 2 □ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of De 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 ☐ Pending investigation 1 ☐ Yes 2 No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical

Ö σ. Division of Vital Records,

Baltimore, Maryland 21215-0036

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

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and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

			Please Type or Pr State of N	i <mark>nt in Black l</mark> i Maryland / Dep			•	_	
			State Registrar	C	ertificate of	Death	R	leg. No. 2	01039
			1. Decedent's Name (First, Middle, Last)				2. Date of Dea Month	th Day Year	3. Time of Death
	Physicia /Medic		Anna Mae Denton				January		4 PM M
	Examin		4a. Facility Name (If not institution, give street and numbe	r)		r Location of Death		4c. County of De	ath
**			605 Tobacco Ridge Road 5. Social Security Number 6. Sex 7. A	Age (In yrs. last birthda		rederick	9 Date of Birth	Calvert	rthplace (State or Foreign
	Funeral Director		212-30-2634 Usual Residence of Decedent	1923 Ma	ountry aryland				
	/land		10a. State 10b. County	10c. City, Town or	Location				10d. Inside City Limits
:	Mary a-fsh	햦	Maryland Calvert	Prince F	rederick				1 □Yes 2 □ No
3	n with the 23a or 28 st be not	Funeral Director	10e. Street and Number 605 Tobacco Ridge Road		10f. Zip Code 20678	3	1	10g. Citizen of What C United	•
0500-C	permit. Pages 1 and 2 should be lied within 72 hours after death with the maryland Department of Health and Mental Hygiene. Interportant, if them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Eventher must be multihed at once.	þ	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced 1 □ Ves 2 □ If Yes, Give Year or Dates	¥Nο	3. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☐ No		pecify Yes or No- Rican, etc.)	14. Race - An Black, Wh Specify:	
<u>۾</u>	z no	sted	15. Decedent's Education (Specify only highest grade completed)		cedent's Usual Occup ve kind of work done		ring	16b. Kind of Busines	s/Industry
717	d within giene.	Completed	Elementary/Secondary (0-12) College (1-4o	life	e clerk	d)		grocery	store
and	tal Hy d oth	Be	17. Father's Name (First, Middle, Last)				•	Maiden Surname)	
<u> </u>	Men Men Marke Marke	은	Hezekiah C. Elliott			Mary 1			
e, Mar	and 2 sn ealth and n 27 is m er traum		19a. Informant's Name/Relationship (Type. Print) Marlyn Sutton — daughter	605	Tobacco I	Ridge Rd.	Prince	r, City or Town, State, Frederick	
baltimore	rages 1 nent of H int; if iter iry or oth		20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ Removal from Stat 4 □ Donation 5 □ Other (Specify)	.	position (Name of rematory or other place Cemetery	January 7		20c. Location - City of Barstow Ma	
Dal	Departr Departr Importa any inju		21. Signature of Funeral Service Licensee		22. Name and Addre	ess of Facility Rai	,	eral Home Republic N	
P	hysician		23a. Part 1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each Immediate Cause (Final disease or condition	line.	enter the mode of dying	-			Approximate Interval Between Onset and Death
	/Medical Examiner			as a consequence of):					
7	executed n and al-transit	Examiner	Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events	s a consequence of):					
,00,	ne be exe iysician ar ne burial-t		resulting in death) Last Due to (or a	is a consequence of):					
/00)	ing pt	Med	IF FEMALE:			······································			
O. DOX	The report of Arenand Privation, the law requires that the death certificate or executed within 24 hours after death. To the Funeral Director; After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Physician/Medical	23b. Was decedent pregnant 23c. If yes, outcome 1 Live birth	2 Fetal death tat time of death	3 □ Ectopic pregnand 5 □ Other (specify) _	су		23d. Date of d Month	elivery Day Year
us, r	signed by	by	Part in Other significant conditions contributing to death but not resulting in the underlying cause given in Part i.						to the cause of death?
ecords,	been	etec					24a. Was a		autopsy findings available
בי בי בי בי	icate has page 2:	Completed					autop: perfor	sy prior to	completion of cause of
7	certil	Be	25. Was case referred to medical examiner?		Oth	26. Place of Dear	· · · · · · · · · · · · · · · · · · ·		
5	ar this	<u>1</u>	27. Manner of Death 28a. Date of Ir	itient 2 ER/Outpat	of 28c. Inju	4 LI Nuising H		ence 6 Other (Sp ow injury occurred	pecify)
5	th.	tion	Natural 5 ☐ Pending (Month, L	Day, Year) Injury		rkí?]Yes 2 □ No			
SIVIO	after dea Director	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of I	njury - At home, farm, etc. <i>(Specify)</i>	street, factory, office		28f. Location (S City or Tow	Street and Number or (n, State)	Rural Route Number,
1	E Funeral	Medical C	29a. Certifier (Check only one) Check only one) Check only one) Check only one) Check only one	of examination and/or	eath occurred at the ti r investigation, in my	ime, date and place opinion, death occu	, and due to the orred at the time, or	cause(s) and manner date and place, and d	as stated. ue to the cause(s)
, i	withir To th comp	Me	29b. Signature and title of certifier	52	29c. Licens	se number		29d. Date signed (Mo January 4	
r RV	D		30. Name and address of person who completed cause of Mukesh Mathur, MD Pri			578			
	Sta Registr			stra#s Signature					
DILLI	H 17 Rev 1/20			man ja	7				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #19a PEr Inf G900 2/17/2010 JH State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year DELORES SITTIG DEVILBISS :00A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death FREDERICK FREDERICK MEMORIAL HOSPITAL If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 215-20-8333 1 🗆 M 2 🖾 F Days Hours Min Months December 30, 1913 96 Maryland **Director** Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Maryland | Frederick Frederick 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
United States Funeral 21701 8 West 14th Street 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Completed 3 Midowed 4 Divorced Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any fijury or other traumatic event, the Me any fijury or other traumatic event, the Me onee. Elementary/Seconday (0-12) College (1-4 or 5+) Secretary Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ William Sittig Catherine Conrad 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret C. <u>Divilbies</u> / Daughter **Devilbiss** 8 West 14th Street, Frederick, Maryland 21701 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State January 18, 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State Mount Olivet Cemetery 2010 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Sery 22. Name and Address of Facility Keeney & Basford P.A. Funeral Home 106 East Church Street, Frederick, Maryland 21701 M01433 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Anset and Death Immediate Cause (Final Physician/ Embeli hour disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director; After this continue has a continue has a continue to the Funeral Director. the burial-trar resulting in death) Last Due to (or as a consequence of): ate has been signed by the attending physician page 2 should be detached for use as the buriar Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Funeral Director; After this certificate has completed filled in by the funeral director, page 2.9 autopsy 1 Yes 2 No ☐ Yes 2 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Hospital: 2 1 No Other: 1 Yes 1 Dinpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 \square Pending 1 Natural injury work?
1 Yes 2 No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ January Henry Dud1ey 2010 3:32 РМ Norment Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 1028 Brinker Dr. Apt.101 Washington Hagerstown 5. Social Security Number 8. Date of Birth (Month, Day, Year) Nov 6 1940 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Months Hours Maryland Director 69 Nov. 214-36-0171 Usual Residence of Decedent "natural", or items 23a or 28a-f show be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director MD Washington 1 X Yes 2 ☐ No Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1028 Brinker Dr. 21740 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. δ 1 Never Married 2 X Married ☐ Yes Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: 3 Widowed 4 Divorced Completed White Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Segonday (0-12) College (1-4 or 5+) Owner/Operator Floor Covering other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert Edward Dudley Elizabeth Katherine Matthews permit. Page 1 and 2 should t Department of Health and Me Important: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peggy J. Dudley/Wife 1028 Brinker Dr., Apt.101, Hagerstown, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State injury or Smithsburg Crematory 1/16/2010 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown, MD permit. Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel S.Ma 1601 Pennsylvania Ave., Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician disease or condition MOON Sugarlo 4 months Medical resulting in death) Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be execute attending physician and for use as the burial-trar Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Month Year page 2 should be detached 9 Unknown has been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 2 100 Completed 1 Tes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed within 24 hours after death.

To the Funeral Director: After this certificate I 1 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 1. ☐ Yes 2. ☐ No Certificate: 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical 29a. Certifier 1 🔀 certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 32, Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2010 Physician/ MAGN 6:50 a M January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Silver Spring Montgomery <u> 15115 Interlachen Drive #202</u> If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Year 1916 Months July 30 1 🔯 M 2 🗆 F Days Hours 93 New York **Director** 109-07-1751 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits **Funeral Director** or 28a-f 1 X Yes 2 □ No Silver Spring Maryland | Montgomery filed within 72 hours after death with the Ma 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 20906 15115 Interlachen Drive #202 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. <u></u> 1 Never Married 2 Married 1 X Yes 2 ☐ No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White Completed 3 X Widowed 4 ☐ Divorced WWII Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 I Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event." (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Federal Government Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Sarah Jacobson Harry Edelman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code $16008\ Walling\ Ford\ Road,\ Silver\ Spring,\ MD$ Glenn Edelman, son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State Judean Memorial Gdns 01/04/2010 Olney, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
EDWARD SAGEL FUNERAL DIRECTION, INC.
1091 Rockville Pike, Rockville, Maryland 20852 MO1255 23a. Part 1. Inter the list se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, in heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death arbry Physician/ ronary disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions. Examine sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 1 🗌 Yes 2 🗌 No 25. Was case referred to medical Certificate; To Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred eral Director: After filled in by the funer Natural 5 Pending 1 Tes 2 🗌 No hours after death 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month)

MI

Dr. Ata Motamedi, 18111 Prince Philip Drive, Suite 101, Olney, Maryland 20832

notam

2. Registrar's Signa

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

0063999

1-2-2010

Baltimore, Maryland 21215-0036

24 hours after deatl filled in by Hospital completely within 24

> State Registrar

Medical

29a. Certifier

(Check only one)

31. Date filed (Month, Day

and manner stated.

completed cause of death (Item 23a) (Type, Print) mo

Registrar's Signature

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND TIEM#30perDVR, 6899, 1/20/2010, WS

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Elva Susan Emerick 2010 4:15 A Jan. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Allegany Allegany Health, Nursing & Rehab. Cumberland | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Sept. | 8, 1 9. Birthplace (State or Foreign Country) West Virginia 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1□M 24□F Yrs. Director 213-22-3810 96 1913 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 XNo Mt. Savage Director MD Allegany 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code or Items 23a 12415 Woodcock Hollow Rd., NW 21545 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White Specify: 3 Widowed 4 Divorced "netural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 6 Homemaker Home other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 should be finance and Mental H permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 is marked o any injury or other traumesis Mary Susan (Ours) Weatherholt Seymour J. Weatherholt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12429 Woodcock Hollow Rd., NW, Mt. Savage, MD21545 Son Leo E. Emerick 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Qurial 2 Cremation 3 Removal from State Restlawn Mem. Gardens Jan 9 2010 LaVale, MD * 4 □Donation 5 □ Other (Specify) 21. Signature of Euneral Service Licensee 22. Name and Address of Facility Hafer Funeral Service, P.A. 1302 National Hwy., LaVale, MD 23a. Part I Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** a END STAGE ALZHEINGR'S DEMENTIA YRS disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence or): Examine The law requires that the death certificate be executed use as the burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760. the attending physicien lan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy or Month Day Year 4□Pregnant at time of death Physic 5 Other (specify) Division of Vital Records. P.O. 9 Unknown 9 Unknown ģ been signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed 2 No To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 this After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident Diractor: in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined after 4 Homicide within 24 hours a To the Funerel I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D-14867 Lunch NAN. 07, 2010 Trano 30. Name and address of person who completed use of death (Item 23a) (Type, Print) Robustiano Barrera 500 Memorial Ave. Ste. 201 Cumberland, MD 21502

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

JAN 20 2010

ORIGINAL

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 1 0 4 5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JAN. 1, 201O REABLE Μ. FOSTER 11:20 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death SANCTUARY AT HOLY CROSS BURTONVILLE BURTONSVILLE MONTGOMERY If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 □**X**F 95 Hours 578-26-7455 RUTMERFORD CT,NC Director Usual Residence of Decedent show 10a. State 10b. County "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c. City, Town or Location 72 hours after death with the Maryland 10d. Inside City Limits Director DC WASHINGTON 1 ¥ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 332 ADAMS STREET, N. E. 20002 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?,
1 Yes 2 A No Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Specify: BLACK Completed 3 XWidowed 4 ☐ Divorced permit. Page 1 and 2 should be filed within 72 hou Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical once. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12TH GRADE College (1-4 or 5+) RETAIL RALEIGHS MENS STORE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည GEORGE EARNEST LOSSIE HAMPTON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GWENDOLYN F. HICKS-DAUGHTER 1205 GRESHAM ROAD SILVER SPRING, MD 20904-1435 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) LINCOLN CEMETERY 1-8-2010 BRENTWOOD, MD eral Service Licensee 22. Name and Address of FacilityPINCKNEY-SPANGLER F. H. 524 - 8TH STREET, N. E. WASHINGTON, DC 20002-5236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner eneum Sequentially list conditions. Examine Due to (or is a consequence of): if any, leading to immediate cause. Enter Underlying Cause Disease or impury or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit Advance that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? 1 Yes 2 No Month Dav Year Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by on Procardid 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2 autopsy performed? Yes 2 No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) examiner? ၉ 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 2 Acciden 5 Pendina Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) 000545 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

Sunitha Bhogavil

31. Date filed (Month, Day, Year)

JAN 0 6 2010

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32. Registrar's Signature

Print in Black Indelible Ink. Ensure All Copies Are segiple		10	1
of Maryland / Department of Health and Mental Hygiene	U	10	-k /

		1	for State Registrar		Cei	rtificate of	Death	R	eg. No.	
			1. Decedent's Name (First, Middle	, Last)				2. Date of Deat Month	h Day Ye	3. Time of Death
	Physicia /Medic		ISAAC FULWO	OOD, JR.				01-03-	-2010	2:58A ^M
	Examin		4a. Facility Name (If not institution				r Location of Death		4c. County of D	
			7628 Allend			Lando		O Data of Birth		George's
	Funeral Director		251-50-1688	6. Sex 1	(In yrs. last birthday) 78 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, 04-27-	Year) 1931	Birthplace (State or Foreign Country)
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
	Mary f sho	to	Maryland Prince	e George's	Landover					1 Yes 2 □ No
	r 28a	Director	10e. Street and Number	deorge 5	Dandover	10f. Zip Code		1	0g. Citizen of What	Country?
	h with	al D	7628 Allendale C	Circle		20785			USA	
	ems ems	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U.S. 13.	Was Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - A Black, W	merican Indian,
20	be filed within 72 hours after death with the Maryland Ital Hygiene. d other than "natural", or items 23a or 28a-f show event, I'n McGral Everigher is set be neithed at	by Fu	1 ☐ Never Married 2 💢 Marri	ied 1 May Yes 2 Mo		1∐Yes 2∭XNo	Specify:	,	Specify: B	
Ş	hours tural		3 ☐ Widowed 4 ☐ Divorced	Year or Dates: 1		dent's Usual Occup	nation		16b. Kind of Busine	
9500-6121	in 72 n "nai	Completed	(Specify only highes	st grade completed)	(Give	kind of work done of DO NOT use retired	during most of work d)	ing	TOD, Tang of Busine	osa madoti y
	filed within Hygiene. other than "	mo;	Elementary/Secondary (0-12) 12th	College (1-4or 5+)		rse		Ţ	J.S. Sold	ier's Home
land 2	e filec al Hy othe vent,	Be C	17. Father's Name (First, Middle, L	Last)			18. Mother's Name		Maiden Surname)	
<u>a</u>	should be and Mental s marked o	2	Isaac Fulwood				Sarah Be	nn		
Mar	2 shoul s and M is mar raumati		19a. Informant's Name/Relationsh				and Number or Rur			
	s 1 and 2 should of Health and Mer item 27 is marke other traumatic		Carrie D. Fulwoo	od/wife			Circle,		r, Maryla 20c. Location - City	
saltimore,	iges 1 If ite or ot		20a. Method of Disposition 1 X Burial 2 ☐ Cremation		20b. Place of Dispo cemetery, cree	natory or other place	ry 01-09		•	Maryland
	it. Pa trimer rrant njury		4 □ Donation 5 □ Other (Sp. 21. Signature of Funeral Service L			2. Name and Addre		2010	ourcrand,	Maryland
g	permit. Pages Department of I Important: If ite any injury or of		May E. Thes	Laman MOI	2711		-	PA Ave.	Suitla	nd,MD 20746
	4		23a, Part 1. Enter the disease, or	complications that caused the	ne death. Do not en				-	Approximate Interval Between
	Physician		shock, or heart failure. List of Immediate Cause (Final	•	ic Prosta	to Cancor	•			Onset and Death
	/Medical		disease or condition resulting in death)	a	consequence of):	te Calicei				6 years
	Examiner		O	h						
_	₽ #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):					
	ecute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c						
Ď,	be ex ician purial		rooding in death, East	Due to (or as a	consequence of):					
09/89	certificate be executed nding physician and ise as the burial-transit	Medical		d						
	∓ ⊙ α ∣		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of	f pregnancy				23d. Date of	delivery
ž Q	death	hysician/	in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live birth 2 4 ☐ Pregnant at t		☐ Ectopic pregnand ☐ Other <i>(specify)</i> _	;y		Month	Day Year
S.	w requires that the death cer been signed by the attendir should be detached for use	hys	9 ☐ Unknown	9 ☐ Unknown						
Š.	requires that the een signed by th nould be detache	by P	Part II. Other significant condition	ns contributing to death but	not resulting in the u	nderlying cause giv	en in Part I.	23e. Did tol		te to the cause of death?
ecord	equire sen si ould t							1 □ Ye	es 2 X No 3[Probably 4 Unknown
ပ္	law r las be	Completed						24a. Was a autops	sv I prior	e autopsy findings available to completion of cause of
<u>=</u>	sician; The law certificate has t irector, page 2 s	Con						perform 1 ☐ Yes	med? deat 2.	h? Yes 2 □ No
VITal	ician sertifi ector,	Be	25. Was case referred to medical examiner?	Hospital:		Oth	26. Place of Deat			
_	D Pi D	٦.	1 ☐ Yes 2 ☐ No 27. Manner of Death	1 ☐ Inpatien	t 2 ER/Outpatie		4 Li Nursing no		ence 6 Other (Specify)
5	ding h. After funer	tion	1 Natural 5 Pending	g (Month, Day,	Year) Injury	Wor	k? Yes 2 □No	Zou. Describe no	SW Injury Occurred	
DIVISION	Atten deat ctor;	fica	3 ☐ Suicide 6 ☐ Could n	not be 28e. Place of Injury	y - At home, farm, str		100 =	28f. Location (St	treet and Number of	r Rural Route Number,
5	al or a after a after I Direct of in b	Certification: To	4 ☐ Homicide determi	building, etc.	(Specify)			City or Town	n, State)	
	To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After Completely filled in by the funera		29a. Certifier 1 Certifyin (Check only 2 Medical	ng Physician: To the best of Examiner: On the basis of e	my knowledge, deat	h occurred at the ti	me, date and place	, and due to the c	cause(s) and manne	er as stated.
	the H nin 24 the Ft tplete	Medical	one)	and manner state						
	Vith To t	Σ	29b. Signature and title of certifier			29c. Licens			29d. Date signed (N	
	6		1 Carry		xon_	MD 03	36496		01-05-201	0
	21		30. Name and address of person	·			.h.i.n.=+	DC 3000.	7	
P	Sta	te	Nancy A. Dawson 31. Date filed (Month, Day, Year)	n 3800 Kese 32. Registrar	rvor Road		mington,	DC 2000	1	
	Registr		JAN 0 5 20	10 Smile	's Signature					

1. Decedent's Name (First, Middle, Last) Month Physician CHARLES FRICK /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 7. Age (In yrs. last birthday) more 6. Sek 10XM 2□ F If Under 1 Year | If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min. Months Yrs. Director 223-46-2786 08/17/1936 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, the Medical Examinar must be notified at Director Jefferson Shenandoah Junction 10g. Citizen of What Country? 10e. Street and Number Funeral 25442 106 Junction Street United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any Injury or other traumatic event, the Medical Examinas and Injury or other traumatic event, the Medical Examinas once. 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Whi<u>te</u> Completed by 3 ☐ Widowed 4 ☒ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) People's Supply Truck Driver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Erma Love Smallwood James Lester Frick ပ 19b. Mailing Address (Street and Number or Rural Route Number, Cify or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Shenandoah Junction, WV 25442 Box 308. Daughter Tammy Carey 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 1/13/10 Smithsburg, MD ne and Address of Facility erson Chapel Funeral Home Jefferson 21. Signature of Funeral Service Licensee Box 838, Charles Town, WV 25414 23a. Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of): Presimonia Plevrel offusions /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) Division of Vital Records, P.O. 9 I Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 20 No 1 □Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after uear... To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 📉 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 1/11/2010 00069015

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

South

32. Registrar's Signature

Greene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2

Year

2010

3. Time of Death

Birthplace (State or Foreign Country)

West Virginia

10d. Inside City Limits

Approximate Interval Between Onset and Death

Year

Day

2 No

Month

1 ☐ Yes

1 ☐ Yes 2 👿 No

1248 am

2. Date of Death

DHMH 17 Rev 1/2001

State Registrar

DRIAN

EDWARDS

filed (Month, Day, Year)

1 - For State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Cora Ella Gilliard 2335 January 2 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Dorchester Dorchester General Hospital Cambridge 8. Date of Birth (Month, Day Ye Aug. 19, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Year) 1926 Months Days Hours 1 □ M 2 🗶 F 218-20-4497 83 Maryland **Director** Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f shov traumatic event, the Medical Examiner must be notified at MD Dorchester Cambridge Director Y Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or USA 520 Glenburn Avenue 21613 death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 6 1 ☐ Yes 2 No Specify: þ Specify: white 3 XWidowed 4 ☐ Divorced Year or Dates "natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) than, Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. Is marked other than seamstress garment 6 . Pages 1 and 2 should be fill tment of Health and Mental H tant: If item 27 Is marked oth 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Bannamen Elzey Inez Fitzhugh 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dennis Gilliard son P. O. Box 233, Secretary, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any Injury or ot
once. 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Dorchester Mem. Park 1/6/10 Cambridge, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Thomas Funeral Home P.A. 21. Signature of Funeral Service Licensee 700 Locust St., Cambridge, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
1 day Immediate Cause (Final **Physician** disease or condition resulting in death) urosepsis /Medical Due to (or as a consequence of): Examiner 1 day pneumonia Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed pulmonary fibrosis 10 years sician and burial-tran Due to (or as a consequence of): Box 68760 chronic lung disease 10 years Physician/Medical the attending p for use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) P.O. detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ ge , diabetes, dementia 1 XYes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? page 2 s autopsy performed? certificate | 1 ☐ Yes 1 ☐ Yes 2 ☐ No or Attending Physician: director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Anpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this After thi funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 1 X Natural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospital o within 24 hours af To the Funeral Di 1\(\bar{\text{L}}\) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 \(\bar{\text{M}}\) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar atricia

31. Date filed (Month, Day, Year)

DANSON

100

32. Redistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar AMEND#12perFH, 1/12/10, BMW, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month January Physician/ 8:43 am 2010 Donald Ray Gochnour Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Bethesda Suburban Hospital 5. Social Security Number 7. Age (In yrs. last birthday) if Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral 1**X □ M 2 □ F Months Days Hours Min. (Month, Day, Year) 165-24-7432 88 Yrs. Director 1921 Idaho July Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of health and Mental Hyglene. Important: If item 27 is marked other than "natural" any injury or other traumatic event. 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 Yes 2 K No Silver Spring Maryland Montgomery 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 20905 USA 720 Marblehedge Way 12. Was Decedent Ever in U.S. Armed Forces? 1X Yes 24 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 X Married White If Yes, Give Year or Dates. 1942–1955 1 ☐ Yes 2 ☐ No Specify. Specify Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) F.B.I. Special Agent 4 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Majden Surname) ဂ္ Albert B. Gochnour Lillie M. Pee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 720 Marblehedge Way, Silver Spring, MD 20905 Ruth Gochnour/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🛣 Removal from State Jan. 7, 2010 Everett Cemetery Everett, PA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Francis Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ abdorginal disease or condition resulting in death) Medical Due to (o as a consequence of): **Examiner** Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury Due to for selections agreement of: the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death. that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 687 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No Month signed by the a Id be detached f 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Kidney ivision of Vital Records, 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has ral director, page 2 death? 1 ☐ Yes 2 ☐ N Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 No Hospital: မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred work?
1 \sum Yes 2 \sum No injury 1 Natural 5 Pending Accident Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deam occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 55410 4

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

1843

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Yevgenry 860000 Between

32 Registrar's Signatur

10-00277 Steven Golub

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 20 10 01050 State of Maryland / Department of Health and Mental Hygiene

		1- For State Certificate Certificate	of Death	Re	g. No.	
Physicia Medical Examir		Decedent's Name (First, Middle,Last)		2. Date of Death Month January 10	Dav Year	3. Time of Death 0915 hrs
		Facility Name (if not institution, give street and number) 14901 Broschart Drive	4b. City, Town, or Location of Dea Rockville		4c. County of Death Montgomery	
Funeral Director	i		If Under 1 Year If Under 24H Months Days Hours M rs.	Irs. 8. Date of Birth	h(MM/DD/YYYY) 9. Birt 24,1957 Foreig Cor	hplace (State or n Washington untry) D.C.
Maryland 28a-f show any d at once.	tor	Usual Residence of Decedent 10a. State	le			10d. Inside City Limits 1 Yes 2 X No
h the Mar 3a or 28s	I Director		10f. Zip Code 20853		g. Citizen of What Cour Inited State	
s afte	by Funeral	1 Never Married 2 Married Armed Forces? If 1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year or Dates:	Vas Decedent of Hispanic Origin? (Yes, specify Cuban, Mexican, Puer Yes 2 No specify:	to Rican, etc.)	14. Race - Americ White, etc. Specify: Whi	te
036 Ithin 72 hour ne. r than "natu	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 12 Dry (ent's Usual Occupation (Give kind o most of working life. DO NOT use re Cleaner		16b. Kind of Business/In	,
1215-00 be filed wintal Hygie rrked other	B	Edward Golub	Olet	ne (First, Middle, Mi ha Eustac	e	
MD 21 d 2 should Ith and Me n 27 is ma n matic ev	٩	Angela Marie Golub (Wife) 4505	ng Address (Street and Number of Dabney Drive	Rockville	, MD 20853	
timore, I. Pages I an Ument of Hea rtant: If ite		1 Burial 2 X Cremation 3 Removal from State crematory or compared to the state of t	itan Crem.	n. 15,	20c. Location - City or Alexandria	
Balt Depart Import injury) East Deer Park		hersburg, N	ID 20877 Approximate Interval
/Medical Examiner		Immediate Cause (Final disease or condition resulting in death) Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): & foc	ssociated with m			Between Onset and Death
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause				
eccuted and - transit	I Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d.				
760, cate be ex physician he burial	Medical	X UNPENDED AMENDED 23a, 27, PII, per 1	ME ,g903 5/7/10	TT	23d. Date of delivery	
ox 68 eath certification attending	Physician/	Program at time of death	etal death 3 Ectopic pregr	nancy	Month D	ay Year
P.O. B es that the digned by the be detached		Part II. Other significant conditions contributing to death but not resulting in the History of alcohol & poly substance			acco use contribute to the	
Division of Vital Records, tal or Attending Physician: The law require rs after death. In Director: After this certificate has been significate has been significated by the funeral director, page 2 should be a proper to the funeral director, page 2 should be a proper to the funeral director.	Completed by	complications		24a. Was an autopsy perform	prior to co death?	opsy findings available impletion of cause of
tal Rec	မိုင် ရှိ	25. Was case referred to medical	26 Place of Death (Check	1 Yes 2	No 1 ✓ Yes	2 No
f Vit	ႍ	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatien 27. Manner of Death 28a, Date of Injury 28b. Time of			esidence 6 🗸 Other:	Scene
Sion of Attending Ph death. Setor: After tay the funeral	Certification:	1 Natural 5 Pending 2 Accident Investigation (Month, Day, Yeár)	1 Yes 2 No	28d Describe ho		
Divis ospital or At hours after d neral Direc y filled in by		3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, stree (Specify)		or Town, Sta		
	edica	C(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation and manner stated, 29b. Signature and title of certifier		at the time, date ar	nd place, and due to the	cause(s)
2-PEND	-	250. Orginal die and title of continer		0446	29d. Date signed <i>(Mont</i> January 12, 2010	n, Day, Year)
	-	30. Name and address of person who completed cause of death (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner				
Sta Registra	te ar	31. Date filed (Month, Day, Year) Registrar's Signature S. Jan 14 2010				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		•	For State State Registrar	Ce	rtificate of D		rentai riyg	eg. N2010	01051
	Physicia		1. Decedent's Name (First, Middle, Last)	HAMILTON			2. Date of Deat Month	h Day Year	3. Time of Death
	Medic Examin		CARLTON 4a. Facility Name (if not institution, give street and not		4b. City, Town, or	Location of Death	JANUARY	4c. County of Dea	
ألمسمريد			107 ONONDAGA DRIVE 5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	FOREST	HEIGHTS If Under 24 Hrs.	8. Date of Birth	0.00	GEORGE S
Ų	Funeral Director		577-66-6449 1 □XM 2 □ F		Months Days	Hours Min.	(Month, Day, AUG 23	Year) 1949 WAS	SHINGTON, DC
	f show	tor	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation				10d. Inside City Limits
	e Mary r 28a-	Director	MD PRINCE GEOEGE 1 10e. Street and Number	S FOREST I	HEIGHTS 10f, Zip Code				Yes 2 □ No
	with th	eral I	107 ONONDAGA DRIVE		20745		1	I0g. Citizen of What C USA	ountry?
	items	Funeral	11. Marital Status 12. Was De	cedent Ever in U.S. 13.	Was Decedent of His If Yes, specify Cuban	spanic Origin? (Spenic Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am	
Maryland 21215-0036	o filed within 72 hours after death with the Maryland Hygiene. Aly bygiene. Aly bygiene do ther than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	ed by		s 2X No iive	1 ☐ Yes 2X No		Thomas of the state of the stat	Black, White Specify:	BLACK
15- 	72 hou n "natu Aedica	Completed	15. Decedent's Education (Specify only highest grade complete	d) (Give	dent's Usual Occupa kind of work done du OO NOT use retired)		ing	16b. Kind of Business	Industry
212	within giene. er tha t, the N		Elementary/Seconday (0-12) College 12TH	(1-4 Or 5+)	RAPHIC DES	IGNER		GOVERN	MENT
and	ntal Hy ed oth event:	To Be	17. Father's Name (First, Middle, Last)			18. Mother's Nam		,	
ar <u>Z</u>	should be file n and Mental 7 is marked o raumatic eve		WILLIAM HAMILTON JR. 19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ing Address (Street ar	PHYLLI nd Number or Rura		LKS City or Town, State, Z	ip Code)
Σ̈́			TANYA HAMILTON/DAUGH	TER 3470	24TH STR				0020
Baltimore,	permit. Page 1 and 3 Department of Healt Important: If item 2 any injury or other once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal fro 4 ☐ Donation 5 ☐ Other (Specify)	m State 20b. Place of Disponent Commetery, creating DTVEDD AT	matory or other place)		20c. Location - City o	
altiu	permit. Pa Departme Importan any injury once.		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee		LE CREMATO 2. Name and Address			RIVERDALE,N KINS FUNE	
8	B E E E	1 3	K. D. Y-hal					ER, MARYLANI	20785
	nysician/		23a. Part 1. Enter the disease, or complications that shock, or heart failure. List only one cause on Immediate Cause (Final	each line.			or respiratory arre	st,	Approximate Interval Between Onset and Death
	Medical Examiner		regulting in death)	ASTATIC GASTR	LC CANCER	TO LUNG			lyr
		er	Sequentially list conditions, b.						_
	uted Id ansit	Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events c.						
			resulting in death) Last Due to	o (or as a consequence of):					
3760	ificate ig phys as the	Media	d						
Box 68	ath certifica attending p	Physician/Medical	in the past 12 months?		☐ Ectopic pregnancy☐ Other (specify)	/		23d. Date of de Month	elivery Day Year
B	the dea	hysic	1 Yes 2 No						
. P.O.	requires that the dea been signed by the s should be detached	b	Part II. Other significant conditions contributing to	death but not resulting in the	underlying cause give	en in Part I.		pacco use contribute to	o the cause of death? Probably 4 Unknown
ords	requir been s should	letec					24a. Was ar	24b. Were au	utopsy findings available
Rec	sician: The law I certificate has b irector, page 2 s	Completed					autops perform 1 \(\sum \) Yes 2	ned? death?	completion of cause of
<u>ta</u>	ician: certific ector,	Be	25. Was case referred to medical examiner? Hospital:		Other	ce of Death (Check	(only one)		
o t <	g Phys er this eral dir	e: To	27. Manner of Death 28a. Dat	Inpatient 2 ER/Outpatie e of injury 28b. Time o	f 28c. Injury	4 ∐ Nursing Ho at		nce 6 Other (Spec w injury occurred	cify)
o	tending leath. or: Aft the fun	Certificate	2 Accident Investigation	onth, Day, Year) injury		∕es 2 □ No			
Division of Vital Records,	al or Att s after d I Direct d in by		4 Homicide determined 286, Place	e of Injury - At home, farm, str ding, etc. (Specify)	reet, factory, office		28f. Location (Str City or Town	reet and Number or Ru , State)	ural Route Number,
_	To the Hospital or Attending Physiciam: with 24 hours after death. To the Funeral Director: After this certifica completed filled in by the funeral director, i	Medical	29a. Certifier 1 X Certifying Physician: To the Check 2 Medical Examiner: On the b	asis of examination and/or inves	stigation, in my opinior	n, death occurred at	the time, date and	d place, and due to the	cause(s) and manner stated.
	To the within To the compl		only one) 3 Certifying Nurse Practione 29b. Signature and title of certifier	. To the best of the knowledge,	29c, License			gd. Date signed (Mont	
			Matilda H. So	MIS		0250		01/04/2	-010
2	8		30. Name and address of person who completed ca MATILDA SO M.D. 1221			IARYLAND	20720		
ı	Stat Registra			Registrar's Signature					

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 01052 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ JANUARY 1 2010 ear 11:53P HAMILTON CALVIN Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death
PRINCE GEORGE Examiner LANHAM 9409 WELLINGTON STREET 9. Birthplace (State or Foreign Country) PORTLAND IAMAICA 5. Social Security Number 220–49–7867 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 68 Yrs **Director** Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f 1 X Yes 2 No LANHAM PRINCE GEORGE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r Funeral 20706 U.S.A. 9409 WELLINGTON STREET within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. ō þ 1 Never Married 2XX Married 1 Yes 2 No Specify: If Yes, Give Year or Dates Spec BLACK "natural" Completed 3 Divorced 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working I Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) PRIVATE CARPENTER 12th Be traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked of ဂ ROSLYN FISHER HUBERT HAMILTON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9409 WELLINGTON STREET LANHAM, MD 20706 19a. Informant's Name/Relationship (Type, Print) Department of Health a Important: If item 27 is any injury or other trai IRIE HAMILTON/WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or off
GATE OF HEAVEN 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 01-01-2010 | SILVER SPRING, MD JB JENKINS FUNERAL HOME 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 7474 LANDOVER RD LANDOVER, MD 20785 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Metustatic Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) sician and burial-transit resulting in death) Last Due to (or as a consequence of). attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by cate has been sig page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

Maryland 21215-0036

3altimore,

Box 68760

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Division of Vital Records,

State Registrar 29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

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32. Registrar's Signatu

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

Jefferson

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D006 48

29d. Date signed (Month, Day, Year)

Rockville mD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No.2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 01/02/2010 **Physician** Royal V. Hart 1423 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Manth, Day, Year) 03/14/1926 Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In vrs. last birthday, Funeral Months Days Hours Min 1 M 2 □ F 544-24-3520 83 Oregon Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Ire Medical Evanirar must be notified at any Injury or other traumatic event, Ire Medical Evanirar must be notified at appear. 10a. State 10b County 10c City Town or Location Annapolis Director 1X Yes 2 □ No MD ANNE ARUNDEL 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 18 Spindrift Way 21403 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Wes 2 □ No IFYES, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) P.G. County Legislative Liaison 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Clarence Hart SR. Lula Vose ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Nancy Hart Spouse 18 Spindrift Way Annapolis MD 21403 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition M01/04/2010 Glen Burnie, MD 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 22. Name and Address of Facility 21. Signature of Funeral Service Liceny Hardesty Funeral Home P.A. Annapolis MD 21401 Daty 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardial or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of). Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, cate has been signed by the attending physician page 2 should be detached for use as the buria IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death
9 ☐ Unknown 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed /24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) (Specify) 2 No 1∐ Yeş 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To After this 24 hours after death.

Funeral Director: After thi etely filled in by the funeral 27. Mannor of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier completely (Check only one) and manner stated To the within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 30. Name and address of per who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day,

Year)

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32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 20 1 - For State 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Vear Physician/ erine 010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Western MD Regional Medical Center Cumberland Allegany If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral Days 1 M 2 F Country 74 **Director** 220-32-4783 Maryland 07/29/1935 Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director MD Allegany Cumberland 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? by Funeral 24 Weber Street 21502 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify 3 X Widowed 4 Divorced Completed Year or Dates. White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) other than College (1-4 or 5+) Elementary/Seconday (0-12) 12 Dietary Department Nursing Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ is marked Charles John Murray Winfield pue 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st.
Department of Health ar
Important: If item 27 is F. Bruce Hymes / Son 1254 Vocke Road, LaVale, Maryland Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State Sunset Memorial Park 01/06/2010 4 Donation 5 Other (Specify) Cumberland. 22. Name and Address of Facility Adams Family Funeral Home, 21. Signature of Funeral Service Ligenses 404 Decatur Street, Cumberland, MD 23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Deatl shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami attending physician and for use as the burial-transit that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy performed? 2 No 2 0 N 1 🗌 Yes To the Hospital or Attending Physician: "within 24 hours after death.
To the Funeral Director: After this certifics completed filled in by the funeral director, to 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Division 1 Yes 2 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 🚅 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21502 Shiv C. Khanna, M.D., 1221 National Highway, LaVale, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar

JAN 0 4 2010

Box 68760

P.O.

of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 7.46 P. M Stanley Tullis Hoover 2010 Januar Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Washington County Hospital Hagerstown Washington County g. Birthplace (State or Foreign West Virginia 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1 X M 2 □ F Months Days Hours Aug. 10, 1932 214-28-5731 Director Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Washington County Hagerstown 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 19509 B Windsor Circle U.S.A. 21742 death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 nan "natural", o 1 ☐ Yes 2 😾 No Specify. Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Statistical Clerk Power Company Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ൧ John F. Hoover Elizabeth Anna Tullis Hoover 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Ravenna J. Hoover-wife 19509 B Windsor Circle Hagerstown, MD 21742 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Rest Haven Cemetery 1-7-2009 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Douglas A. Fiery Funeral Home)auc 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ ACUTE disease or condition resulting in death) MTOCALDIAL INFANCETION Medical Due to (or as a consequence of) Examiner CANDIAL Sequentially list conditions, Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to for as a consequence of: Examir RESPIRATORY and Due to (or as a consequence of) physician a Physician/Medical law requires that the death certificate be PAILUNG Box 68760 ası the attending IF FEMALE: nse 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No for Pregnant at time of death Month Day Year 1 Yes 2 9 Unknown Unknown P.O. signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ CORONAM MITERY DIJEATE Records, 1 Yes 2 No 3 Probably 4 Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death? BRAIN INJURY 24a. Was an has page 2 performed? Yes 2 No this certificate 1 🗌 Yes 2 🗌 No Hospital or Attending Physician: Division of Vital 25. Was case referred to medical director Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 X No 1 🗌 Yes ဂ္ 1 Linpatient 2 ER/Outpatient 3 DOA in 24 hours after deau.

The Funeral Director: After th 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and title of certifier 29c. License number 000 62006 5/2010

DHMH 17 Rev 7/2009

State

Registrar

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31. Date filed (Month,

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gistrar's Signature

HAM ERSTOWN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WIRBNY

MITAKO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 8:00 P M George Garfield Hoffman 3 2010 January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 430 Pangborn Blvd. Hagerstown Washington County If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) Date of Birth (Month, Day, **Funeral** Months Days Year) Hours 1 X M 2 □ F 214-09-6050 97 Director October 0 3,1912 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b, Count d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at Director Maryland Washington County Hagerstown 1 ☐ Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number filed within 72 hours after death with I Hygiene. Ither than "natural", or items 23a or 430 Pangborn Blvd. 21740 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 MNo If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: White Completed by 3 X Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Clerical Worker Sand Blastin Company 12 should be filed w h and Mental Hygie 7 is marked other tl 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Chester Hoffman Ruth Norford Hoffman Reynolds 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is n any Injury or other traun once. R. Scott Hoffman-son 13115 Woodburn Dr. Hagerstown, MD 21742 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Rose Hill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 1-7-2010 Hagerstown, Maryland 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licenses 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear dailure. List only one cause of each line.

Immediate Cause (Final **Physician** · cars resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Physician: The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Be Completed by Physician/Medical as IF FEMALE: use f yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy for Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) ned by the a detached f ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? significant conditions contributing to death but not resulting in the underlying cause given in Part I 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has 1 □Yes 2 No 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) Hospital: 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this filled in by the funeral 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after deatl To the Funeral Director; 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Zi Medical Examiner: On the basis of examination and/or investigation in my opinion, death accurred at the time. 29a, Certifier completely (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title

SH-4

State Registrar

DHMH 17 Rev 1/2001

completed cause of death (Item 23a) (Type.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year Physician Orville HART Januar 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Western Maryland Hospital Center Washington Hagerstown If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 87 Director 219-12-0010 20 1922 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County Department of Health and Mental Hygiene. mportant: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 Y Yes 2 No Director Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21740 821 Washington Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ∏ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 👿 No Specify. 3 X Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hospita1 0 Housekeeping 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Harry Hart Clara B. Mills 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1417 Salem Avenue, Hagerstown, Md. 21740 Ronald L. Hart - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Lawn Mem. Park: 1/8/2010 Hagerstown, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Minnich Funeral Home Molera Strank 415 E. Wilson Blvd. Hagerstown, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ARREST **Physician** CARDOPULMONARU disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner , CERE BROVASCULAR Se uentially list conditions Due to (or as a consequence of). if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine certificate be executed burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 9☐Unknown Month Year Dav 5 ☐ Other (specify) signed by the at Id be detached fo 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ARTERY DISEASE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an page 2 s has autonsy certificate 2**□**No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No P 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred the Funeral Director: After in pletely filled in by the funeral Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Box 68760. P.0. Division or Vital Records,

altimore, Maryland 21215-0036

Hospital or Attending within 24 hours at To the

Registrar

31. Date filed (Month State

29b. Signature and title of certifier

29a. Certifier

PAMLINE

Medical

DALEY

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

and manner stated.

MI

29c. License number

D0002895

Hagerstown, MD

1500 Pennsylvania Avenue

6, 2010

JANUARY

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month Day, Year)

32. Registra

JAN 0 4 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2010 1:12 A Donald Frank Hall Januarv Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince Georges Southern Marvland Hospital <u>Clinton</u> 7. Age (In yrs. last birthday) If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 - F Months Days Hours July 26 ^{Year} 1929 New York Director 087-20-7325 80 Usual Residence of Decedent 10a. State ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 10d. Inside City Limits 1 Yes 2 □ No Maryland 10e. Street and Number Prince Georges Camp Springs 10f. Zip Code 10g. Citizen of What Country? Funeral <u>4604 Westridge Place</u> 20748 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give 10 0. Black, White, etc. 1 Never Married 2X Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", Year or Dates. 1953-196 3 Divorced 4 Divorced Specify: White 1 and 2 should be filed within 72 hour of Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Fairfax County Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Superintendent School 5 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Katherine Batt Frank Hall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5204 Sturgeon Ct. Waldorf, Maryland 20603 Page 1 and 2 Karen Pfeil/ Daughter Department of Healt Important: If item 2 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, Maryland Vet. Cemetery Jan. 12, 2010 Cheltenham, MD. 4 Donation 5 Other (Specify) Signature of Funeral Service 22. Name and Address of Facility Huntt Funeral Home <u>3035 Old Washington Rd. Waldorf, MD.</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) Month 1 Yes 2 G Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 \square Yes 2 \square No 3 \square Probably 4 \square Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Yes 2 No 1 Yes 2 No Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) in 24 hours after deam. he Funeral Director: After this ce moleted filled in by the funeral dire Hospital 2 No Other: မ 1 🔲 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1. Natural 5 Pending work Accident Suicide 1 Tes 2 🗆 No Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined edical 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 within 2 To the I only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type. 32. Regis State rar's Signature 6 201 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 01060 State of Maryland / Department of Health and Mental Hygiene [] | [] For State Registrar Amend#12,per FH,QACHD,1/6/10,ms Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** 0 *3010* /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 XM 2 ☐ F Months Days Hours Director 221-26-9877 66 8/14/1943 DE Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show r than "natural", or Items 23a or 28a-f show 1 XYes 2 No Director MD Millington Kent 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 314 Middle Street 21651 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Xes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Yes. Give Specify Specify: Black þ Year or Dates: P/a 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, If a Mones. College (1-4or 5+) 12 Board of Education Maintenance 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဂ္ဂ Thomas N. Henry Mary Frances Davis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kerry Henry/nephew 13 Sir Barton Ct. Newark, DE 19702 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/11/2010 Delaware Veterans Bear, DE 22 Name and Address of Facility. Fellows, Helfenbein & Newnam Funeral Home 370 W. Cypress St. Millington, MD 21651 21. Signature of Funeral Service Licenses Kud A 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Thyscare **Physician** disease or condition resulting in death) /Medical as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be executed y pertension burial-tran Due to (or as a consequence of) physician s the burial Division of Vital Records, P.O. Box 68760, Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? Month Year Day 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No ate has been signed by the page 2 should be detached 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate UD 1 ☐ Yes 24 hours at er death.

9 Funeral Director: After this certific letely filled by the funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide completely filled Hospitai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated within 2 To the I To the 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) Do069453 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Nasiv Ramin MD 119 (North main St Galena MD) 37. Registrar's Signature 31. Date filed (Mont State Busca Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? 1 - For State Registra Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician 45 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If net institution, give street and number) Examiner 15 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) **Funeral** Days Min 1 M 208 F 220-80 Yrs Director Usuet Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Completed by Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip (or items 23a Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Maritaf Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or item any injury or other treumatic event, tra Medical Examinare page. □Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 TNo Specify. If Yes, Give Year or Dates: Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surna 17. Father's Name (First, Middle, Last) Be ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or 19a. Informant's Name/Relationship (Type, Print) 20b. Pface of Disposition (Name of 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 1-20-2010 * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of all Service Light RUGER J HASON 8 AUE RIVERDALE 23a. Part 1. Enter tradiseas or commiscations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he or failure districtions on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Is then the mode of dying, such as cardiac or respiratory arrest, shock or he or failure disease or condition resulting in death) Approximate Interval Between Onset and Death **Physician** /Medical Due to (or as a consequence of): Examiner Sequentiafly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last HEMSI. Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed burial-tran the attending physicien and Due to (or as a consequence of): P.O. Box 68760, Physician/Medical markid obes detached for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetef death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ■ Yes 2 □ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, pe 2 No 3 Probably 4 □Unknown page 2 should Be Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? 25 No 1 Yes 1 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To ¥ZYes 2 □ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Yeer) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Injury 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No death. 2 Accident investigation after death the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) filled in by Hospitel within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License numbe 29b. Signature and title of certifier whia is. D005508 1/12/10 JUUV. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) plater ND 20646 11655 (4 w: Day, Year) 0 2011 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JÄNUARY 2010 DOROTHY ELIZABETH TEICHEN JEWELL 6:25 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 6026 THE TERRACES BALTIMORE BALTIMORE If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Number 8. Date of Birth **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 🗆 M 2 🗶 F JUNE 3. 1934 ILLINOIS **Director** 75 .328--28-6355 Usual Residence of Decedent "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗷 Yes 2 🗌 No MARYLAND BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6026 THE TERRACES 21209 UNITED STATES and 2 should be filed within 72 hours after death wealth and Mental Hygiene.

Sem 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc. Completed by 1 Never Married 2 X Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 Tes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: WHITE Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) NURSE HEALTH Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I ဂ္ CARL FREDRICK TEICHEN FRIEDA MARIE SCHNEIDER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) THOMAS GILLIS JEWELL/HUSBAND 6026 THE TERRACES, BALTIMORE, MARYLAND 21209 Department of Healt Important: If item 2 any injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place)
ST PETERS
CATHOLIC CEMETERY 20a. Method of Disposition 20c. Location - City or Town, State JANUARY 6 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 2010 QUEENSTOWN, MARYLAND permit. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MARYLAND 21619 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition resulting in death) Lance T Onset and Death - Small Cell Lun Physician/ YPETS Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) I by the attending physician and stached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Month Year ate has been signed by the a page 2 should be detached 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 🗆 Yes 2 🗆 No 3 Probably 4 🗀 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 24a, Was an autopsy performed certificate funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 🗌 Yes 2 မ To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director, After this 1 Inpatient 2 ER/Outpatient 3 DOA 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident 1 Yes 2 🗌 No Investigation completed filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0056919 K. heut 10 megen 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. 6569 N CHARLES STREET #205, TOWSON, MARYLAND 21204 ROBERT DONEGAN 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar park

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Henrietta Louise Kalinowski 2010 7:30 A /Medical <u>January</u> 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Calvert 1220 Sledge Way St. Leonard If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 02-04-1924 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F Months Days Hours Min. Director 85 047-12-6750 Connecticut Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits a or 28a-f show show Director 1 ☐ Yes 2 ☐ No Calvert St. Leonard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23a 1220 Sledge Way 20685 1 and 2 should be filed within 72 hours after death [,] Health and Mental Hygiene. em 27 is marked other than "natural", or items 23. Completed by Funeral USA Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 2 X No 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🕱 No Specify: Specify: 3 X Widowed 4 ☐ Divorced white 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) librarian library 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Joseph Golesky Viola Malinowski 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i other tra Valerie Kapitan, daughter 1220 Sledge Way, St. Leonard, MD 20685 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages Department of Important: If it any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 01-04-10 | Alexandria, VA 22. Name and Address of Facility Rausch Funeral Home, P.A. 21. Signature of Funeral Service Licensee William 4405_Broomes Is. Rd., Port Republic, MD 20676 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) EMENT **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate
Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): burial-transit and Due to (or as a consequence of): attending physician Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? has autopsy certificate perform 1 □ Yes 2 🗆 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 ☐ Yes 2 🗷 🗖 o 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

the death certificate be executed P.O. Box 68760 Division of Vital Records, Hospital or Attending Physician: after death

Director: within 24 hours aft

To the Funeral Di

completely filled in

Baltimore, Maryland 21215-0036

State

Medical

29a. Certifier (Check only one)

2671

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

10004

32. Registra Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number 050233

HUSPIML DR, H310

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death January **Physician** I,2010 Joseph E. Keane 12:01 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 101 Sunset Drive Anne Arundel Annapolis 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 05/20/1936 Months Days Hours 1 M 2□ F Washington DC 579-46-2468 73 Director Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City, Town or Location show 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Iversion Experies or must be rediffed Director 1 ☐ Yes 2 🙀 No MD Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 101 Sunset Drive 21403 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 DYes 2 No
1 Mes, Give Year or Dates: 54-62 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. em 27 is marked other than "natural", or itel 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No White þ Specify Specify 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired)
Printer College (1-4or 5+) Elementary/Secondary (0-12) Sauls Lithograph 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Henry Edward Keane Bernice Botts ഉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara J. Keane Spouse 101 Sunset Drive Annapolis, MD 21403 permit. Pages 1 and 3 Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition
1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Atlantic Crematory 01/04/2010 Glen Burnie,MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Pungfal Service Licensee 22. Name and Address of Facility Hardesty Funeral Home P.A Annapolis, MD 21401 204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician TNOE 1 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) the □Yes 2□No 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ icate has been siç 7, page 2 should b 1/□/√es 2 □ No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate 1 ☐ Yes 2 🗆 No 1 ☐ Yes 2 ☑ No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this After th funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending n 24 hours after death.

Reference American Street death. 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier within 24 hor To the Fune completely fi (Check only one) 29b. Signature and title, of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2010 11800 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CH 5+1 State

Registrar
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Annimous mis

21401

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32. Registrar's Signature

TKIN

31. Date filed (Mont.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Renee Maria Kamenker Jan. 2010 7:10 a Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery General Hospital 01ney Montgomery 8. Date of Birth (Month, Day, Year Sept. 20, Birthplace (State or Foreign Country) 5. Social Security Number 065-24-5449 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Days Months Hours 1 ☐ M 2 🛣 F **Director** Sept. 193 Austria Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director Maryland Montgomery Silver Spring 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò Funeral items 23a 3701 International Drive 20906 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12, Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. ō þ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates "natural" 3 X Widowed 4 Divorced Completed White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) than Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. 4 IT Specialist Insurance Be Father's Name (First, Middle, Last)
 Hugo Kurzer 18. Mother's Name (First, Middle, Maiden Surname) Hilda Beck permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan E. Oseroff/Cousin 11607 Gilsan St., Silver Spring, MD 20902 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disprosition Date 1 Durial 2 Crem ation 3 🔀 Reploval from State Mt. Moriah Cemetery 5 Cother (Specify) Fairview, New Jersey Prancis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 2090 Approximate 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line erval Between Onset and Death Immediate Cause (Final -Physician/ disease or condition resulting in death) Medical Respiratory failure **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exami that initiated events resulting in death) Last Physician/Medical certificate be attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy 5 Other (specify) Day Year Pregnant at time of death ed by the a 9 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 2 No Yes 2 N 1 Yes Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 20 ဂ္ Inpatient 2 ER/Outpatient 3 E 4 Nursing Home 5 Residence 6 Other (Specify) thin 24 hours after death.

the Funeral Director: After thi
mpleted filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 only one 29b. Signature and title of 29d. Date signed (Month, Pay, Year)

Registrar

31. Date filed (Month, Day, Year)

JAN 04

2010

Baltimore, Maryland 21215-0036

68760

Box

P.O.

Records,

Division of Vital

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

18101 Prince Philip Drive, Olney, MD 20832

005 9414

State of Maryland / Department of Health and Mental Hygiene 01066 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** JAN.7,2010 DOROTHY JUANITA KINTER 4:12A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** CHARLES 6037 SIRENIA PLACE WALDORF 8. Date of Birth (Month, Pay, Year) 10-24-1925 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** 1 □ M 2 🔀 F Months Days Hours 267-20-9472 84 Director Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City. Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.

Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examples Longitudes. Director MD. CHARLES WALDORF 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6037 SIRENIA PLACE U.S.A. 20603 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 🔀 Married Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 XNo à Specify: Specify.WHITE 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) F.B.I. Elementary/Secondary (0-12) College (1-4or 5+) SPECIALIST FINGERPRINT U.S.GAVT. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be LEON A. ROLIN LEONA C. LAYTON ۵ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ERIC KINTER-SPOUSE 6037 SIRENIA PL. WALDORF, MD. 20603 3altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition N Burial 2 ☐ Cremation 3 ☐ Removal from State MD. VETERANS CEM. 1-14-2010CHELTENHAM, MD. 4 Donation 5 Dother (Specify) 2. Name and Address of Facility 21. Signature of Funeral Service Licensee MO0479 RAYMOND FUNERAL SERVICE, P.A. I.A PI.ATA, MARYI, AND 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 0 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner I or Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the aftending physician and physician and the burial-trans resulting in death) Last Due to (or as a consequence of): Box 68760; Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Ye ar 5 Other (specify) P.O. 1 TYPS 2 No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Anknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 □Yes 2 □No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Deat 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Division 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No the f 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d, Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, 23 32. Registrar's Signature 31. Date filed (Month, Day, Year, State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 | 0 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2010 Physician/ Elizabeth Agnes Ledbetter January 2, 5:51 a Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 12908 Moray Road Silver Spring Montgomery 8. Date of Birth (Month, Day, Sept. 5, Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** Min. 1 □ M 2 🗗 F Months Hours 171-01-5492 100 Director Pennsylvania Usual Residence of Decedent 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Director Maryland Montgomery Silver Spring 1 🗌 Yes 2 🏝 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20906 12908 Moray Road USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14, Race - American Indian Armed Forces Black, White, etc. ģ 1 Never Married 2 Married Yes 2 No 1 ☐ Yes 2 🙀 No Specify: If Yes, Give Specify: White 3 Midowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Small Business Elementary/Seconday (0-12) College (1-4 or 5+) id Mental Hygiene. marked other tha Accountant Administration Be 17. Father's Name (First, Middle, Last 18. Mother's Name (First, Middle, Maiden Surname) မ Michael J. Senko, Sr. Anna Gazda 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12908 Moray Road, Silver Spring, MD 20906 19a. Informant's Name/Relationship (Type, Print) Judith A. Ledbetter / Daughter permit. Page 1 and 2: Department of Health Important: If item 27 any injury or other troones. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Calvary Cemetery 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🖳 Removal from State 2010 4 ☐ Donation 5 ☐ Other (Specify) Drums, Pennsylvania of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 1 Kile Colley 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Acute Myocardial Infarction Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Atherosclerosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): certificate be executed burial-transi Hyperetension Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy 5 Other (specify) ____ death Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy certificate 1 ☐ Yes 2 ☐ No Yes 2 XXIV To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica after death.

Director: After this certific 25. Was case referred to medica Be 26. Place of Death (Check only one) Hospital 2 XNo 7 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide completed filled in by determined City or Town, State) Medical 29a. Certifier Pertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) 0 12 D40279 January 4, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David Young, 4530 Wisconsin Avenue, NW, #104, Washington, DC MD Registrar's Signature Registrar

21215-0036

Maryland

Baltimore,

68760

Box (

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Terry R. Ley 11:00a™ 2010 Medical January 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 8522 Biggs Ford Road Walkersville Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 1 M 2 □ F **Director** Yrs. 174-38-8800 1947 Pennsylvania Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No <u>Marvland</u> Walkersville Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8522 Biggs Ford Road United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. ģ 1 Never Married 2 X Married 1 X Yes 2 If Yes, Give 2 🗆 No Maryland 21215-0036 1 Yes 2 No Specify: Completed 3 Divorced 4 Divorced Year or Dates. Vietnam White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Therapist Medical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Raymond Ley Clare Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vera McCullough Ley/ Wife Baltimore, Bracken Street, Johnstown Pennsylvania 15909 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place, 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Lawn Cemetery | Jan.6.2010 Johnstown, Pennsylvania 21. Signature of Peneral Service kicens 22. Name and Address of Facility Stauffer Funeral 1621 Opossumtown Homes P. A. Pike, Frederick, Maryland 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between et and Death Immediate Cause (Final Vodevlan Accident Physician erabar disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner a consequence of: Se uential, list conditions if any, leading to immediate cause. Enter Underlying Examiner with Obstructure Sleepaprer attending physician and for use as the burial-transit Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Terbil Obesit resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Year Pregnant at time of death Yes 2 No ate has been signed by the page 2 should be detached Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>چ</u> Losteria Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Hnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 🔀 No 1 🗆 Yes 2 🗆 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 No 1 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 Natural 2 Accident injury 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certif 29c. License number 29d. Date signed (Month, Day, Year) D46248 1/4/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 300 w 2h street

Registrar

State

Registrar's Signature

Pierce

Fredorch MO 2124

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hydiene

			For State OI State Registrar	Maryland / L		tificate of			Reg. No. 20	0	01069
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	Funeral			. Age (In yrs. last bir		If Under 1 Year Months Days		8. Date of Birt (Month, Da	th y, Year)	9. Birth	place (State or Foreign ntry)
	Director		217-36-5910 1⊠ M 2□ F Usual Residence of Decedent	97	Yrs.			Sept. 2	8,1912	Penn	sylvania
	/land low		10a. State 10b. County	10c. City, Town	n or Lo	cation					10d. Inside City Limits
	aa-f sh tiffed	ctor	Md. Montgomery	Chev	y C						1 X Yes 2 No
	vith th	Funeral Director	10e. Street and Number			10f. Zip Code			10g. Citizen of Wh		ntry?
	ns 234 must	erai		dent Ever in U.S.	13.	208 Was Decedent of H	815 Iispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No	- 14. Race	- Ameri	can Indian,
320	be filed within 72 hours after death with the Maryland ttal Hygiene. d other than "natural", or items 23a or 28a-f show event, if with clied Examiner must be notified at	þ	Armed Ford 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced Armed Ford 1 □ Yes 3 If Yes, Give Year or Da	2 <mark>∑</mark> No ∍		lfYes,specifyCuba 1 ∐Yes 2⊠No		Rican, etc.)	Specify:	, White, Wh	
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yland	2 should be fi n and Mental I Is marked of raumatic eve	To B	John Francis Leonard, Jr				Henrie		rri <u>son</u>		
Mar			19a. Informant's Name/Relationship (Type. Print)	l l	922	1 Gue Roa	and Number or Ru		er, City or Town, S	State, Zi	p Code)
a,	t 1 and 2 Health tem 27 other tra		Alice L. Dove/Daughter 20a. Method of Disposition	20b. Place o	Dam f Dispo	ascus, Mo	aryland 2	Date	20c. Location - C	City or T	own, State
Ê	Pages nent of ant: If its ary or o		1 🖾 Burial 2 □ Cremation 3 □ Removal from S 4 □ Donation 5 □ Other <i>(Specify)</i>	tate Gate Ceme	of	sition (Name of matory or other place Heaven	Jan 20	10	Silver S	pri	ng, Md.
Baitimor	permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other Once.		21. Signature of Funeral Service-Licensee M00	215		2. Name and Addre			ineral Ho Jashingto		.C. 20007
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o uo	Attending Physician: If death. ector: After this certifics by the funeral director, p	ition: T	27. Manner of Death 1 ☑Natural 5 ☐ Pending (Monte 2 ☐ Accident investigation		Time o Injury	Wo	ry at rk?]Yes 2 □ No	28d. Describe	how injury occurre	ed	
DIVISION OF	ipital or Attendli burs after death. eral Director: A filled in by the fu	Certification: To		of Injury - At home, fang, etc. (Specify)	arm, st	reet, factory, office		28f. Location (City or To	Street and Number wn, State)	er or Ru	ral Route Number,
	4 4 P S	Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the 2 Medical Examiner: On the band mann	asis of examination a	je, dea nd/or ir	th occurred at the to envestigation, in my	ime, date and place opinion, death occu	e, and due to the urred at the time	e cause(s) and ma , date and place, a	nner as and due	stated. to the cause(s)
	To the Hos within 24 h To the Fun completely	Me	29b. Signature and title of Cartifier	Mast	/	29c. Licen	se nu m ber		- 29d. Date signed	(Month	n, Day, Year)
	20		Mountain sa	ujuny			2338		January	4,	2010
			30. Name and address of person who completed cause Richard P. Delaney, M.D.				, Wheato	n, Md.	20906		
	Sta		31. Date filed (Month, Day, Year) 32/R	egistrar's Signature		west.					
	Registr	ar	JAN 05 2010 1/21	acres a M.	1891	The state of the s					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2 Date of Death Decedent's Name (First, Middle, Last) Month Day 4c. County of Death **Physician** 190 an /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** The Johns Hopkins Hospital **Baltimore City** If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) Days **Funeral** 1. 1961 Philippines 218-31-5180 48 May Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 Is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Examiner must be notified at 1 Yes 2 No Director Centreville VA Fairfax 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number U.S.A. 14560 Old Mill 20121 Funeral Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 2 Specify: 3 Widowed 4 Divorced Asian Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a Decedent's Usual Occupation the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Restaurant 12 Restaurateur 18. Mother's Name (First, Middle, Maiden Surname) or other traumatic event, 17. Father's Name (First, Middle, Last) Be Lucio Dalgo Catalina Galo ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any injury or other trau 14560 Old Mill Rd. Centreville, VA 20121 Nabil Lakkis-Husband 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 🕱 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Jan. 13,2010 Fairfax, VA Fairfax Memorial 22. Name and Address of Facility Fairfax Memorgal Funeral Home 21. Signature of Funeral Service Licensee Bernatte Danish CCOHSI 9902 Braddack Rd. Fairfax.

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 9902 Braddock Rd. Fairfax, VA 22032 Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** meumonia disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Leukemia Myclogenus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) physician Division of Vital Records, P.O. Box 68760, Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 - Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 No 4 Pregnant at time of death
9 Unknown Month Year Day 5 Other (specify) the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 □ Probably 4 □ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DCA မ this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: eral Director: After filled in by the funer 5 Pending investigation 1 Yes 2 No death. 2 Accident 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Hospital within 24 hours a hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State

Registrar

31. Date filed (Month, Day, Year)

JAN 20 2010

DEZUDE 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Hegistrar's Signature

RES-000

Januar

600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
RegistrarAMEND#19aperFH, 1/5/10, EMW, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Jan 1,2010 Lanier Park Mclachlen 6:40am Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** May 26, 1921 Months 579-20-9572 Director 88 Wash DC Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location be filed within 72 hours after death with the Maryland Director 10d. Inside City Limits MD 1 X Yes 2 No Montgomery Bethesda 10f. Zip Code 10g. Citizen of What Country? Funeral 9707 Old Georgetown Rd #2205 20814 United States 11. Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specity Yes or No 14. Race - American Indian Armed Forces?

1 4 Yes 2 Nekn If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: "natural", Specify: White 3 Divorced Year or Dates of Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical ∫ 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Banker Banking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lanier Park McLachlen Sr. Evelyn Stevens . Page 1 and 2 should ment of Health and N tant: If item 27 is ma 19a. Informant's Nar Malago hil Ene/Spouse 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Esther McLauhlen 9707 Old Georgetown Rd #2205, Bethesda, MD 20814 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1
Department of
Important: If it
any injury or o cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State National Crematory 01/04/2010 4 Donation 5 Other (Specify) Falls Church, VA 21. Signatule of Funeral Service Licen ²²Joseph Gawler's Sons, INC 5130 Wisconsin Washington DC 20016 23a. Part 1. Enter the disease, or complications that dused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Pulmonary Edema Medical Due to (or as a consequence of) Examiner Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter ordenying Cause (Disease or iinjury Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed <u>Anemia</u> attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box (3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year 4 ☐ Pregnant 9 ☐ Unknown n signed by the a ld be detached for g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 😾 No 3 ☐ Probably 4 ☐ Unknown After this certificate has been si funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed? Yes 2 X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?
1 \(\subseteq \text{Yes} \) 2 \(\subseteq \text{No} \) Vital le B 26. Place of Death (Check only one) Other: ျ 1 K Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ot 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred X Natural injury 5 Pending Division work? 1 ☐ Yes 2 ☐ No Accident Investigation Director; / 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours arter
To the Funeral Dir Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one ٩ 29c. License numbe 29d. Date signed (Month, Day, Year) Doo65720 Jan 1,2010

State Registrar 30. Name and address of person w

Rosemary Iwunze MD

Gaorgetown

Road, Bethesda, MD 20814

eted cause of death

8600 01d

32. Registrar's Si

		Please Type or Print in Black Indelible Ink. Ensure Al State of Maryland / Department of Health and N	•	•	
		1 - State Certificate of Death	F	leg. No. 2	0 01072
		1. Decedent's Name (First, Middle, Last)	2. Date of Dea Month	th Day Year	3. Time of Death
Physici /Media		Mary R. Marshall	Januar	· ·	12:00 a M
Examir	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Dea	th
,у		Renaissance Gardens at Riderwood Village Silver Spring 5. Social Security Number 6. Sex 7. Age (In vis. last birthday) If Under 1 Year If Under 24 Hrs.	0 0-4-40-4	Prince G	
Funeral Director		5. Social Security Number 171-01-0577 6. Sex 1	8. Date of Birth (Month, Day May 13,	1915 Pe	thplace (State or Foreign ountry) nnsylvania
and		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
Mary -f she	to	Maryland Prince George's Silver Spring			1 □Yes 2 □NO
r 28a	Funeral Director	10e. Street and Number 10f. Zip Code		10g. Citizen of What C	ountry?
h with	a D	9113 Saffron Lane 20901		USA	
death	ner	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp. 17. Marital Status 13. Was Decedent of Hispanic Origin? (Sp. 17. Marital Status 14. Marital Status 15. Marital Status 16. Marital Status 16. Marital Status 17. Marital Status 17. Marital Status 17. Marital Status 18. Marital Status 19. Marital S	ecify Yes or No-	14. Race - Am	
72 hours after death with the Maryland natural", or items 23a or 28a-f show Iteal Evan Inst Toust be notified at	þ	1 □ Never Married 2 □ Married 1 □ Yes 2 □ No 1 □ Yes 2 □ No 1 □ Yes 2 □ No Specify: 3 □ Widowed 4 □ Divorced Year or Dates:	Tiloan, etc.,	Black, Whi	
ithin 72 hours afine "natural", or han "natural", or	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation		16b. Kind of Business	/Industry
e. an "n	ed L	(Specify only highest grade completed) (Give kind of work done during most of work life. DO NOT use retired)	ing		
d wit	Son	12 Secretary		Banki	ng
d be file ental Hy ced oth	Be (17. Father's Name (First, Middle, Last) 18. Mother's Name	e (First, Middle,	Maiden Surname)	
Ment Barker arker artic e	ျှ	August Rohrbach Harri	et Thom	as	
and sand	T Y	19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rur			-
and 2 ealth n 27 I		Ann L. Marshall/Daughter 9113 Saffron Lane, Sil			
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, the Madreal Evan her must be notified at once.	r	1 Burial 2 Cremation 3 Removal from State	n. 5	20c. Location - City o	Town, State a, Virginia
permit. P Departm Importal any Inju		21. Signature of Funeral Service Licensee 22. Name and Addees of Facilities Francis		1 Home Inc	
B B B B B		500 University Blv	d. W.,	Silver Spr	ing, MD 20901
Physician /Medical Examiner		23a. Part 1. Env the disease, or complications that cause in the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Pneumonia Due to (or as a consequence of):	or respiratory an	rest,	Approximate Interval Between Onset and Death 1 WEEK
ifficate be executed g physician and as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause fursease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of):			
attending for use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)		23d. Date of do Month	Blivery Day Year
w requires that the diberon signed by the should be defached	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		bacco use contribute	
w requires been sign should be	ted	Dementia, Weight Loss	1 □ Y	es 2X[No 3L F	Probably 4 ☐ Unknown
sician: The law certificate has b irector, page 2 st	Completed		24a. Was a autop: perfor 1 □Yes	sy prior to med? death?	utopsy findings available completion of cause of
ding Physician: The In. After this certificate hit funeral director, page	Be C	25. Was case referred to medical 26. Place of Deat			
tysic ais ce direc	10 E	examiner? 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Normal Hospital:	ome 5 🗌 Resid	ence 6 Other (Sp	ecify)
ng PI fter th	Ë	27. Manner of Death 11☑ Natural 5 □ Pending 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Work? 28c. Injury at Work?	28d. Describe h	ow injury occurred	
tendir leath. tor: A	atic	2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No			
or Att fter de Directe in by ti	ertification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (S City or Tow	treet and Number or F n, State)	lural Route Number,
pital urs a eral [O	200 Cortifier W Contifue Dhysisians To the best of my leaveledge death segured at the time date of the segured at the size of the			
the Hospital or hin 24 hours afte the Funeral Dir npletely filled in	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and manner stated. 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and manner stated.			
	Ž	29b. Signature and title of certifier 29c. License number	2	29d. Date signed (Mor	
10		MISHUES NO D24093		Jan. 4,	2010
4		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mark Parkhurst, MD 3110 Gracefield Road, Silver Sp	ring, M	D 20910	
Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature			
Registr	ar	JAN 05 2010 Senter B. Janes.			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ onth Morris Calvin Medical Richard 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death WMHS- RMC Cumberland Allegany Birthplace (State or Foreign Country)
 MD Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Hours 1 □ M 2 □ F Director May 1936 214-34-2038 Usual Residence of Deceder 28a-f shov 10a. State 10c. City, Town or Location 10b. Count ral", or items 23a or 28a-f sho Examiner must be notified at 10d. Inside City Limits Director MD Allegany Cumberland 1 □XYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11215 Brown Hill Road 21502 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 □ ★es 2 □ No
If Yes, Give Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ XNo Specify: "natural", Completed 3 🗆 Widowed 4 🗆 Divorced WW II white Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Kelly Sprinafield Tire truck driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, and Mental P ည Thelma Hamilton Morris Forest Morris, Sr. 1 and 2 should by Health and Meitem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11215 Brown Hill Road Cumberland MD 21502 Richard Morris Jr. son injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a Department of H Important: If ite 20c. Location - City or Town. State ■ Burial 2 ☐ Cremation 3 ☐ Removal from State 1/8/2010 4 Donation 5 Other (Specify) Restlawn Memorial Gardens MD LaVale 21. Signature of Fundal Service Licenses 22. Name and Address of Facility
Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 Part 1 Ent. The disease, or complications that caused show, or heart failure. List only one cause on each line or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a cor equence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-transit Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year been signed by the s should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of certificate has be lirector, page 2 sl autopsy performed? death? 1 Yes 2 No after death.

Director: After this certific 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes Other: 2 -1 100 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: the Hospital or Attending Natural 5 Pending iniury work?
1 Yes 2 No Division 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined To the Hospital or A within 24 hours after To the Funeral Dire completed filled in b Medical Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certif 29c. License number 29d. Date signed (Month, Day, Year) 5,2010 D0017565 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NOS LaVaie 921 N2+ 1 AJBolline MD (20 21502 31. Date filed (Mor 32. Registrar's Signature State arke

DHMH 17 Rev 7/2009

Registrar

Box 68760

P.O.

Records.

of Vital

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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		For State		State of N	naryiai		tificate of	Health and Death	ivientai ny	_			
Physicia		D. 1	e (First, Middle, Last,	Markle			imodio or	Dodan	2. Date of Do Month	Day	Z U _{Year}		ne of Death
Medic Examin		4a. Facility Name (if	not institution, give s				4b. City, Town,	or Location of Dea	th	<u> </u>	2015 County of Dear		723
		WMH	S- RMC				Cun	berland			Allega		
Funeral Director		5. Social Security No. 233-34	-3791 ^{1[}	X □ M 2 □ F 7. A X	ge (In <i>yr</i> s. 82	last birthday) Yrs.	If Under 1 Year Months Day			av. Year)		thplace (St untry)	tate or Foreign
nd how at	٦	Usual Residence of 10a. State	Decedent 10b. County		10c. Ci	ty, Town or Loc	cation					10d. Insid	de City Limits
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	MD	Alleg	jany		Cu	mberlan					1 □	yes 2 □ No
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Page nent c ant: If ary or			☐ C re mation 3 ☐ I 5 ☐ Other <i>(Specify)</i>				atory or other pi Funeral Ho		1/5/201	• •	Cresapt	own	MD
permit. Departr Importa any inju		21. Signature of Fur	eral Service License	<u>*</u>		22	. Name and Add	ress of Facility Irpelli Funera	I Home PA			-	
<u></u>		1	VVV				108	Virginia Ave	nue: Cumb	erland,	MD 21502	-	
		sh ck, or hear Immediate Cause (I	he disease, or compl t failure. List only one Final	e cause on each lir	ne.	771179Q							kimate I Between and Death
Physician/ Medical		disease or condition resulting in death)		a. Due to (or as			ATCDIA	LINF	ARCTI	ON		3 D	AYS
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ysician; is certific director,	Be	25. Was case referre examiner?	/ h	lospital:				Place of Death (Che	eck only one)				
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nding ath. r: Afte e fune	icate	1 ☑ Natural 2 ☐ Accident	5 Pending Investigation	(Month, Da	ay, Year)	injury	wo	rk? ☐ Yes 2 ☐ No	Zod. Describe	now injury	occurred		
r Atte ter de recto	Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of In building, e			et, factory, office		28f. Location (City or Tou		Number or Rui	al Route N	lumber,
pital o									1				
To the Hospital or Attending Physician; The law requires that the death certificate be within 24 hours after death certificate has been signed by the attending physicic rompleted filled in by the funeral director. After this certificate has been signed by the attending physicic completed filled in by the funeral director, page 2 should be detached for use as the burner and the funeral director.	Medical	(Check 2	Certifying Physic Medical Examine Certifying Nurse	er: On the basis of	examinatio	n and/or investi	gation, in my opin	nion, death occurred	at the time date:	and place	and due to the d	ause(s) and	d manner stated.
To the within To the comp	2	29b. Signature and t		Practioner. 10 the	/	y Kriowiedge, d	7	se number	lace, and due to tr		and manner as		r)
10		> Yleb	ustrano	(). 1	Sau	era, J	(0	-1486	5	JAN	V 104	2	DID
		30. Name and addre	ess of person who co	mpleted cause of	death (Item	23a) (Type, Pr				0.			NE AO
// Ass Stat	•	KOBUST 31. Date filed (Month	IANO BP	32. Registr	rar's Siena	ture /	ORTEV	VST. SW	IT 500	uy	MB.IY	102	7005
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Registrar DHMH 17 Rev 7/2009

State

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

32. Registra#s Signature

Deneur

JAN 0 6 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Physician / Microstor Funeral Director Funeral	Time of Death 4:00 P ^M (State or Foreign MD
Physician / Microstor Funeral Director Funeral	4:00 P ^M (State or Foreign
Examiner Family Name (In institution, jive streat and number) Harford Carden Care Center Harford Carden Carden Care Center Harford Carden Care Center Harford Carden Car	(State or Foreign
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STAIR A. HARMI MD, 821 N. EUTAW ST SWILL 30 & BRITIMORE MD 2	ion of cause of No Ite Number,
21/1/12 11 11 12 (12) N. OVIIINO II OWILL SIA DIFFERENCISE IIID 2	ion of cause of No ide Number, cause(s)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 3:25 p M January 4, 2010 John T. Murphy /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Calvert 4310 Shady Lane Huntingtown 8. Date of Birth (Month, Day, Year) If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Hours Days 1 M 2 □ F Months Director August 5, 1925 NY 224-52-6479 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show ?7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Modical Experience must be notified at 1 ☐Yes 2X No Director Huntingtown MD Calvert 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code within 72 hours after death with USA 20639 Funeral 4310 Shady Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? 1 ■Yes 2 □ No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No ş Specify: 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 h and Mental Hygiene. 7 is marked other than "r College (1-4or 5+) Elementary/Secondary (0-12) Cabinet Maker Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 Wesley Murphy Minnie Hart 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any Injury or other traionce. 4310 Shady Lane, Huntingtown, MD 20639 Evelyn Parker-Murphy - wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 1 ☐ Burial 2 🗷 Cremation 3 🔀 Removal from State Metropolitan Crematory | January 6, 2010 | Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Sewell Funeral Home, P.A. Gladen 1451 Dares Beach Rd., Prince Frederick, MD 20678 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** congestive disease or condition resulting in death) /Medical Due to (* as a consequence of): Examiner 403 471 5 Se wentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine The law requires that the death certificate be executed , or orary avter and burial-tran resulting in death) Last Due to (or as a consequence of) Box 68760, attending physician Physician/Medical the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Por Month Year Day 4 Pregnant at time of death 5 Other (specify) P.O. signed by the a ☐Yes 2 ☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy performed certificate 1 □Yes 2 ☑No 2 No 1 Yes 25. Was case referred to medical examiner? director. Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred After or Attending 5 Pending investigation 1 Matural after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only one)

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(Month, Day,

29b. Signature and title of certified

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and manner stated.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

within 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ January RITA S. NEAGLE 3° 2010° 5:45 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery General Hospital 01ney Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 M 2 X Months Days Hours 4/2871928 New York Director 089-20-9207 81 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. Count 10c. City. Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🕅 No MD Derwood Montgomery 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 7109 Roslyn Ave. 20855 United States Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. ğ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes Give 1 ☐ Yes 2 X No Specify. 3 XWidowed 4 Divorced Specify: Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)

Survey Assistant Elementary/Seconday (0-12) College (1-4 or 5+) Historic Landmarks Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Bradford Sherwood Honora Sheehan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7109 Roslyn Ave. Derwood, MD 20855 Louise Neagle (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 🕅 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Indianapolis, IN Crown Hill Cemetery 21. Signature of Funeral Service Lice 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Drive Gaithersburg, MD 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Preumonia Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) DAYS Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause (Disease or iirijury nding physician and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: for use 23c. If yes, outcome of pregnancy
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3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State within 24 hours a To the Funeral L 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) H0065661 3 2010

Registrar
DHMH 17 Rev 7/2009

MONTGOMERY

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burn	Medical	(Oncon only	Examiner: On		amination ar						nd place, and du		
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		30. Name and address of per Carol Allan, MD		pleted cause of Medical Exa			Street, Balti	imore, MD	21201				
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DHMH 17 Rev 1/2001

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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Medical Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner them Many land Hospita lintor ocorac's 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace State or Foreign Funeral 1 🗆 M 2 🙀 Months Days Hours MARCH De Year 1943 MARYLAND Director 213-46-8328 66 Usual Residence of Decedent show 10a, State 10b. County 10c. City, Town or Location with the Maryland Examiner must be notified at 10d. Inside City Limits Director 28a-f 1 Yes 2 □ No MARYLAND PRINCE GEORGES TEMPLE HILLS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 23a Funeral 4309 23RD, PLACE 20748 UNITED STATES items ? 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race ~ American Indian Armed Forces2 1 ☐ Yes 2 🔼 No Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. P Completed by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: BLACK "natural", 3X Widowed 4 □ Divorced Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed, d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 11TH GRADE COOK / DIETICIAN FOOD SERVICE Be 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked ott any injury or other traumatic even 18. Mother's Name (First, Middle, Maiden Surname) |GEORGE ANDERSON BRISCOE MARY ELIZABETH BENNETT BRISCOE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 1813 FENWOOD AVENUE, OXON HILL, MARYLAND AARON H. PRICE / SON Baltimore, 1 \$\overline{\Omega}\$ Burial 2 \$\overline{\Omega}\$ Cremation 3 \$\overline{\Omega}\$ Removal from State 4 \$\overline{\Omega}\$ Donation 5 \$\overline{\Omega}\$ Other (County) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State . Page 1 MARYLAND VETERANS CEMETERY JANUARY 12,2010 CHELTENHAM, MARYLAND natura of Funeral Service License .22, Name and Address of Facility
THORNTON FUNERAL HOME, P.A.
3439 LIVINGSTON ROAD, INDIAN HEAD, LADIA C. THORNTON JOHNSON M00583 MARYLAND 20640 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery Ectopic pregnancy Pregnant at time of death 5 Other (specify) Month Day Year Yes signed by the a g 🗌 Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown should . Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 performe certificate 1 Yes 2 No 21 25, Was case referred to edical examiner? Division of Vital funeral director. 26. Place of Death (Check only one) Be Hospital: Other: 4 \(\triangle \) Nursing Home 5 \(\triangle \) Residence 6 \(\triangle \) Other (Specify) 1 Tyes 2 **N**o မ 1 Inpatient 2 I ER/Outpatient 3 I DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending work 2 🗆 No 1 Yes after death Director: / Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one 29b. Signature and title of 29c. License number 29d, Date signed (Month, Day, Year, who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person

Registrar

Ami

31. Date filed (Month, Day,

701

32. Registrar's Sign

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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Examin	er	4a. Facility Name (if not institution,				4b. City, Town, o					nty of Death	IMIDDI.
Funeral		ANNE ARUNDEL M 5. Social Security Number		EK Age (In yrs. la	st birthdav)	ANNA] If Under 1 Year		der 24 Hrs.	8. Date of Birth		NE AR	place (State or Foreign
Director		220-22-1195 Usual Residence of Decedent	1 X M 2 □ F	81	Yrs.	Months Days	Hours	s Min.	MAY 20,	Year 1928		YLAND
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ge 1 and 2 should be filed within 72 hour t of Health and Mental Hygiene. If item 27 is marked other than "natu or other traumatic event, the Medical		20a. Method of Disposition 1 X Burial 2 Cremation	3 Removal from Sta		metery, crei	osition (Name of matory or other plac	ce)	JANUA	Pate 7	20c. Locatio	n - City or To	own, State
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permit. Page 1 and 2 sh Department of Health a Important: If item 27 is any injury or other trau once.		21. Signature of Fune al Service Li	censee	teo.	$ \mathbf{F} $	2. Name and Addre ELLOWS, H 06 SHAMR(ELFE	ENBEIN	AND NE	WNAM F	UNERAI	L HOME, P.A. 21619
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Medical Examiner		resulting in death)	Due to (or a	s a conseque		J = 1					\neg	7110. 1177
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ithin 2 ithin 2 orthe	ž	only one) 3 L Certifying 29b. Signature and title of certifier	Nurse Practioner: To the	ne best of my	knowledge,	death occurred at th				cause(s) and 29d. Date sign		
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10ths		30. Name and address of person w	no completed cause or	f death (Item		1 1 6	12	1.77	_ ^	1	ND 21	40\
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month O Physician/ 2010 3:00 AM Rose amuel Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death University of Maryland Medical (enter Baltimore 8. Date of Birth (Month, Day, Year) JULY 15, 1974 Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours Min. 1 🔀 M 2 🗆 F 35 216-06-1543 Director **GEORGIA** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MARYLAND HARFORD **ABERDEEN** 1

Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 114 ST. MATTHEW COURT 21001 UNITED STATES 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Black, White, etc. Completed by 1 X Never Married 2 Married 1 X Yes 2 □ No If Yes, Give Baltimore, Maryland 21215-0036 Specify: AFRICAN 1 ☐ Yes 2 🔀 No Specify: 3 Divorced 4 Divorced Year or Dates. 1992-95 AMERICAN 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) HONOR GUARD MARINE CORPS Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ SAMUEL LEE ROSE, JR JOHNNIE LEE FREDERICK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOHNNIE LEE ROSE / MOTHER 114 ST MATTHW COURT, ABERDEEN, MARYLAND 21001 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State BERKLEY CEMETERY 01/08/10 4 Donation 5 □ Other (Specify) DARLINGTON, MD Signature of Funeral Service Licenses 22. Name and Address of Facility
LISA SCOTT FUNERAL HOME,
552 LEWIS STREET, HAVRE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician Acquired. immune deficiency disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to manie list cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Due to for as a consequence of To the Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-transil Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 2 No cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by disease cardiany opathy, pulminary rengl 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy **Director:** After this certificate I 2 1 No 1 Tes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Other: 1 Tes 2 🗹 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 D Inpatient 2 ER/Outpatient 3 DOA 27. Manper of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No ☐ Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide within 24 hours a

To the Funeral C

completed filled Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 1457586232 adum on Reese 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

I+IVA State

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month, Day, Year)

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Bultimore MD

22

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32. Registrar's Signature

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Baltimore,	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service	Licensee			ne and Addre		ausch F					•
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	To the Hospital or Attending Physician: with 24 hours after death. To the Funeral Director: After this certification in the funeral director, sompletely filled in by the funeral director,	edical		ng Physician: To the best Examiner: On the basis o and manner st	f examination a									use(s)
	To the within 2	Me	29b. Signature and title of certifie				29c. Licens	se number			ate signed			ar)
			- CAPIFE			(D	DU	1404		Jan	uary	4,	2010	
RU	20+1		30. Name and address of person Charrett Martin	who completed cause of d		(Type, Print)		edenick	, No		7.00	78		
	Sta		31. Date filed (Month, Day, Year,		ar's Signature	6	1	R						
	Registr	ar	JA	N 0 5 2010 /	Kneera	A. A.	Maken							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ JAN. 2010 1704 1. М ROBINSON PHYLLIS Ζ. Μ. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c, County of Death **Examiner** PRINCE GEORGE'S CLINTON SOUTHERN MARYLAND HOSPITAL 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days 1 - M 2 - YF Months Hours Min. 1000210a1942 WINCHESTER. VA 67 577-56-5182 Director Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location Director 1 DXYes 2 □ No CAMP SPRINGS PRINCE GEORGE'S MD 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r Funeral U.S.A. #E-209 20746 4331 TELFAIR BLVD. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or item ledical Examiner n 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian. Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 Married þ If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Specify: BLACK Completed 3 Divorced Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) r than " Ith and Mental Hygiene. 27 is marked other than r traumatic event, the M Elementary/Seconday (0-12) College (1-4 or 5+) YEARS U. S. COAST GUARD HEALTH CARE BENEFIT ADMIN. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic evenone. ပ GLOVER ROBINSON ESTELLE LOSSIE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7231 SWIFTROCK RIDGE TER. CHESTERFIELD, VA 23838 STEPHANY D. OFFICER -DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place, MD NATIONAL MEMO. PARK 1-9-2010 LAUREL. MD 4 Donation 5 Other (Specify) Signature of Funeral Service License 22. Name and Address of Facility PINCKNEY-SPANGLER F. H. 524 - 8TH STREET, N. E. WASH., DC 20002-5236 23a. Part 1. Enter the disease, or complications that cause the shock, or heart failure. List only one cause on each "e.e." death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine Due to (or as a if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events -transit resulting in death) Last Due to (or as a consequence of) the burial-Physician/Medical as 1 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Vear Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4XXUnknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a, Was an autopsy page . death? Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 🗆 No 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA မှ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 🔼 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Hospital or Attending Physician: The law requires that the death certificate be executed and physician Division of Vital Records, P.O. Box 68760 the þ signed b certificate has After this s after death.

I Director: Aff

with the Maryland

death v

72 hours after

within 7

Maryland 21215-0036

Baltimore,

To the Hospital or Atte within 24 hours after de To the Funeral Directo completed filled in by the

4 Homicide

Date filed (Month, Day, rear,

29a. Certifier (Check

State Registrar 29b. Signature and title of person who completed cause of death (Item 23a) (Type, Print) 7503 SURRATTS ROAD WENDELL PIRSON, M.D.

determined

3209 CLINTON, MD 20735

1 Certifying Physician: To the basis my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the sist of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Continuing Nurse From the Total Continuing State of the time, date and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Route Number,

City or Town, State)

32. Registrar's Signature

Medical

10-00116 Suzanne Riley

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1. For State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ 0023 hrs SUZANNE CREGGER RILEY Medical Examiner January 4, 2010 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Frederick Frederick Frederick Memorial Hospital If Under 1 Year If Under 24Hrs. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Foreign Country) Maryland Months Davs Hours Min June 12, 1964 Director 213-84-3489 45 1 M 2 X F Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Yes 2 X No Frederick Myersville Marvland Examiner must be notified at once. within 72 hours after death with the Maryland Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21773 3967 Wistman Lane U.S.A. Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces 1 Never Married 2 Married Yes Yes, Give Yea Yes 2X No specify. Specify: White 3 Widowed Divorced \$ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na injury or other traumatic event, the Medical Exp. Elementary/Secondary (0-12) College (1-4 or 5+) Dishwasher Restaurant 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Barbara Stull Raymond Poole 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11015 Powell Road, Thurmont, Maryland 21788 Tina Smith / Foster Sister 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State crematory or other place) 1/8/10 Smithsburg, Maryland Smithsburg Crematory Donation 5 Other Specify signature of Funeral Pervice Lo 22. Name and Address of Facility
ROBERT E. DAILEY & SON FUNERAL HOMES 21788 615 EAST MAIN STREET, THURMONT, MD Approximate Interval Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician failure. List only one cause on each line Medical Death Anoxic Encephalopathy Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Bronchopneumonia Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate Examine course. Enter Underlying Course (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and Physician/Medical AMENDED 23a,b,pt.II,27 per me g901 3-25-10 vt X UNPENDED physician a Division of Vital Records, P.O. Box 68760, 23d. Date of deliver 23c, If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year attending properties for use as the 1 Live birth 3 Ectopic pregnancy Month Dav Fetal death 2 past 12 months? Pregnant at time of Other (Specify) 1 Yes 2 V No 9 Unknown 9 Unknown the signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Yes 2 ✓ No 3 Probably 4 Unknown Completed by Asthma, Chronic Obstructive Pulmonary Disease 24b. Were autopsy findings available page 2 should 24a. Was an prior to completion of cause of autopsy this certificate has performed? death? 1 🗸 Yes ✓ Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical Be Hospital: 1 ✓ Inpatient 2 Other 4 Nursing Home 5 Residence 6 Other ER/Outpatient 3 DOA 1 🗸 Yes After 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death the Hospital or Attending hin 24 hours after death. Certification: 1 X Natural 1 Yes 2 Pending Director: the Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc Could not be Suicide determined within 24 hours a To the Funeral I (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29d. Date signed (Month, Day, Year) 29b Signature and title of certifie 29c. License number January 7, 2010 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Victor Weedn MD JD 31. Date filed (Month, Day, Year 32 Registrar's Signature State Corperada Registrar

DHMH 17 Rev 1/2001 OCMF 2006

ORIGINAL

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January 1:00 am Joseph Walter Roland 201°0 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Holy Cross Hospital Silver Spring Montgomery Social Security Number If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) D.C. 1 ፟ M 2 □ F Months Days Hours March Day, Year 577-32-6265 Director 1926 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9505 Pin Oak Drive 20910 IISA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 14. Race - American Indian, Armed Force If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married ∃Yes 2 🖺 No hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify: ^{Specify:}White If Yes, Give "natural", Completed 3 X Widowed 4 Divorced Year or Dates. permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16h, Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 1 2 College (1-4 or 5+) Cartographer Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Joseph Jefferson Roland Elizabeth Margaret Halbhuber 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9505 Pin Oak Drive, Silver Spring, MD 20910 Joseph J. Roland, II/Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 8, 1 XBurial 2 Cremation 3 Removal from State Jan. Rock Creek Cemetery Washington, DC 4 Donation 5 Other (Specify) 2010 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc 21. Signatur of Funeral Service Licensee Klisa 500 University Blvd. W., Silver Spring MD 2090: 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Ascites Medical Due to (or as a consequence of): Examiner Liver Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to for as a consequence of Examir Cause (Disease or linjury Renal Failure physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical that the death certificate be Cirrhosis Box 68760 nding puse as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? ģ 5 Other (specify) Month Day Year Pregnant at time of death 2 No 9 Unknown 9 Unknown P.O. been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hospital or Attending Physician: The law requires Records, 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an cate has | page 2 s autopsy performed certificate Yes 2 X No 25. Was case referred to medical examiner?
1 ☐ Yes 2 😾 No director, Division of Vital Be 26. Place of Death (Check only one) Hospital: Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) ဂ္ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred After work? 1 🗶 Natural iniury 5 Pending death. Accident
Suicide Investigation within 24 hours after death

To the Funeral Director: / 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 3 [29b. Signati e and title of certifie 29c, License number 29d. Date signed (Month, Day, Year) မ d66249 January 4, 2010

Registrar

DHMH 17 Rev 7/2009

State

1500 Forest Glen Road, Silver Spring, MD 20910

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

Jonathan Duran, MD

JAN 05

31. Date filed (Month, Day, Year,

			4
	Physici /Medic Examin	an al er	1 E 4
REED, RAY MONO # A27581 Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examinar ment be neithed at once.	To Be Completed by Funeral Director	1 R 4 (5 5 L 1 M 1 1 1 1 1 1 1 2 2 2 2 2 2 2 2 2 2 2
	Physician /Medical		l c

Division of Vital Records, P.O. Box 68760,

	1 - State Of IV Registrar	Cei	rtificate of D		Reg. I	2010	01087
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cal	Raymond Lee Reed 4a. Facility Name (If not institution, give street and number	0	45 07 7		JANUARY	2 201	01.45 4 1
ner	CIVISTA MEDICAL C	ENTER	4b. City, Town, or L	Ocation of Death	'	4c. County of Dea	7001
	5. Social Security Number 6. Sex 7. A	ge (In yrs. last birthday)		If Under 24 Hrs.	8. Date of Birth	9. Bir	thplace (State or Foreign
		65 Yrs.	Months Days	Hours Min.	(Month, Day, Yea		hington D.C.
	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation				10d. Inside City Limits
ţ	Maryland Charles	Waldorf					XXYes 2□No
irec	10e. Street and Number	Waldori	10f. Zip Code		10g.	Citizen of What Co	ountry?
a D	18 Greystone Circle		20602		III	SA	
uner	11. Marital Status 12. Was Decedent Armed Forces	Ever in U.S. 13.1	Was Decedent of His If Yes, specify Cuban,	panic Origin? (Spec		14. Race - Ame Black, White	
Be Completed by Funeral Director	1 Never Married 2 Married 1 Yes 2 M	No		Specify:	,	Specify:	
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Son	12 2	Superv	isor			Authori	ty
Be	17. Father's Name (First, Middle, Last)				(First, Middle, Maid	'en Surname)	
မ	Preston Reed Sr.			<u>Annis Str</u>			
	19a. Informant's Name/Relationship (Type. Print) Annie Reed/ wife		_{ng Address (Street an} Eystone Ci			-	•
	20a. Method of Disposition		sition (Name of matory or other place)			Location - City or	
	1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)			i		·	
	21. Signature of Funeral Service Licensee	Resurrect	ion Cemete 2. Name and Address	- 6 E Otto	ntt Funera	-	Maryland
		1190 30	035 01d Wa	shinaton	Rd. Walde		20601
	23a. Part 1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each I	d the death. Do not entine.	er the mode of dying,	such as cardiac or	respiratory arrest,		Approximate Interval Between
	Immediate Cause (Final disease or condition	Cardio Ke	sprator	Arre	18		Onset and Death
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Exa	resulting in death) Last Due to (or as	a consequence of):	101.				
Be Completed by Physician/Medical Examiner	d	via betes	Mellita	\$			
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cian	in the past 12 months?	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
ysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown	it time of death 32					
Y P	Part II. Other significant conditions contributing to death b	out not resulting in the ur	nderlying cause given	in Part I.	23e. Did tobacc	o use contribute to	the cause of death?
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plet	Chronic Ren	al to	eri Cure		24a. Was an autopsy	24b. Were at	utopsy findings available completion of cause of
Con					performed?	? death?	2 □No
Be	25. Was case referred to medical examiner? Hospital:		Othor	26. Place of Death	(Check only one)		
5	1 ☐ Yes 2 No Prospilar 1 ☐ Impati 27. Manner of Death 28a. Date of Inju			4 LI Nursing Hom	e 5 Residence		cify)
itior	1 Natural 5 □ Pending (Month, Da 2 □ Accident investigation	ay, Year) Injury	Work?	s 2 No	ou. Describe now in	jury occurred	
ifice	3 Suicide 6 Could not be 28e. Place of Inj	jury - At home, farm, stre	eet, factory, office	28	3f. Location (Street	and Number or Ri	ural Route Number,
Cert	4 I Hornicide Building, et	c. (Specify)		25	City or Town, Sta	are)	
ical	29a. Certifier (Check only (Ch	of my knowledge, death	h occurred at the time	e, date and place, ar	nd due to the cause	e(s) and manner a	s stated.
Medical Certification: To	one) and manner st	ated.	29c. License r				
	A I has a	6				Date signed (Mont	
	30. Name and address of person who completed cause of c	teath (Item 23a) /Time	Print)	1108	01	10210	2010.
	Dil A III A	Medical	Center	7-CPas	TOFFICE	Rd. Wal	2010. dorf,MD2602
te	31. Date filed (Month, Day, Year) 32. Region	rar's Signature	1			-	1
ar	JAN 0 6 2010 🔀	was D. x	parke				

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM# 3perPHYS#20b, perFH, G899, I/19/2010, WS
State of Maryland / Department of Health and Mental Hygiene 0 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JAN. Day 2010 **Physician** THOMASINE RODERICK 12:19AM M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner CIVISTA MEDICAL CENTER LA PLATA CHARLES If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2X F AUG.27,1920 WASH. Director 579-16-1989 .D.C Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10h. County 10a State d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director MD CHARLES WELCOME 10g. Citizen of What Country? 10e. Street and Number 10f Zin Code with 20693 8555 WEDDING DRIVE U. S. Funeral 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 XNo 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Yes 2 🔀 If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2X No Specify Specify: WHITE 2 3℃Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 should be filed with and Mental Hygier 7 is marked other the HOMEMAKER AT HOME 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) æ MARY TASSA THOMAS BONI ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important; If item 27 is any Injury or other tra once. PEARTREE COURT BOWIE, MARYLAND 20721 MICHAEL RODERICK/SON 1511 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Pages 1 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 1/12/2010 RESURRECTION CEM. CLINTON, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility RAYMOND FUNL.SERVICE, P.A. 5635 WASHINGTON AVE., LA PLATA, MD 20646 21. Signature of Funeral Service Licensee Lound Bant M00641 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician CON6007 IVE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner AORTIC SONOSI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Box 68760, Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ Ño Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) o 9 Unknown ed by t detach signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by FIBRILLATION 2 No 3 Probably 4 Unknown 1 TYes 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ▷ 🛪 Ro 24a Was an page 2 s autopsy performed? Yes 2 certificate 1 ☐ Yes Division of Vital director, 25. Was case referred to medical examiner? 26. Place of Death (Check only on-) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2DNo 1 mpatient 2 ER/Outpatient 3 DOA မှ this After thi 27. Manner of D ath 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Hospital or Attending 1 Natural 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical 29a. Certifier 1 Detrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated.

12 State

Registrar

31. Date filed (Month, Day, Year)

d title of certifier

29b. Signature

30. Name and address of person who completed cause of death (Item 23a) (Type Print)

NELS ON BENEDIS, 9131 PLANTAN AD, 32. Registrar's Signature

29c. Ligense number

29d. Date signed (Month, Day, Year)

010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 5070 Jean James Thomas Spivey 6:00 lanuary Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Prince George's Southern Maryland Hospital Clinton 8. Date of Birth (Month, Day, Year) Social Security Number Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days 1 X M 2 - F Hours **Director** 243-58-4676 71, Usual Residence of Decedent 28a-f shov iral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Directo 1 X Yes 2 No Prince George's Clinton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9001 Goldfield Place 20735 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", 3 Widowed 4 Divorced Black Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Bus Operator Transportation Be Department of Health and Mental H Important: If item 27 is marked oth any injury or other trees. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frances Bell James Lee Spivey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9001 Goldfield Place, Clinton, MD Willia Mae Spivey/Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Resurrection 07/06/5070 Clinton MD 21. Signature of Funeral Selvice 22. Name and Address of Facility Strickland Funeral Services 6500 Allentown Rd - Camp Springs MD 20748 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician SIN ev disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last the attending physician thed for use as the buria Physician/Medical requires that the death certificate be Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Pregnant at time of death signed by the a d be detached for 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ should be Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 📜 inknown peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? Hospital or Attending Physician; The law 124 hours after death.

e Funeral Director: After this certificate has le autopsy performed' 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: ဂ္ 1 Tes 2 000 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Nature. 2 Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29b. Signature and title of certi anne A 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar illipm

31. Date filed (Month, Day, Year)

JAN 0 8 2010

Anne

32. Registrar's Signature

11701

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	1 - State of Maryla		artment of F		ntal Hygien Reg. N	211111	01090
	Physicia	_	1. Decedent's Name (First, Middle, Last) Lorraine SIEGE			_	Date of Death Month anuary 1,	ay 2010 Year	3. Time of Death 4:10 A M
	/Medic Examin	_	4a. Facility Name (If not institution, give street and number) Sligo Nursing and Rehab.		4b. City, Town, o	r Location of Death	4	c. County of Deat	
	Funeral Director			vrs. la <i>st birthday)</i> 8 Yrs.	If Under 1 Year Months Days	Hours Min. Ma	Date of Birth Month Day, Yea Y 19, 19	21 New	hplace (State or Foreign
	aryland show	_	,	City, Town or Lo					10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	the Margarite	Funeral Director	Maryland Prince Georges 10e. Street and Number	Greent	10f. Zip Code		10g. C	itizen of What Co	
	ath with	rai D	22 Ridge Road #319			20770		ited Sta	
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene importent: If item 27 is marked other then "natural", or Items 23a or 28a-f ehow empty injury or other treumatic event. In Medical Examinar must be notified at ADD.		11. Marital Status 1 Never Married 2 Married 3 NWidowed 4 Divorced 12. Was Decedent Ever in Armed Forcas? 1 Never Married 2 Married If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 No	dispanic Origin? (Speci an, Mexican, Puerto Ric Specify:	ly Yes or No- can, etc.)	14. Race - Ame Black, White Specify:	
Maryland 21215-0036	within 72 ho ane. then "natur be Medical	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give	dent's Usual Occup b kind of work done DO NOT use retire al Secret	during most of working d)	16b.	Kind of Business/	·
and 2	d be filed value Hygie ted other t	Be	17. Father's Name (First, Middle, Last) Herman Heller			18. Mother's Name (First, Middle, Maide Younger	n Sumame)	
Mary	nd 2 should the and Me 27 Is mark	2	19a. Informant's Name/Relationship (Type, Print) Laurie Siegel, Daughter	19b. Maili 7B R	ing Address (Street	and Number or Rural P , Greenbel	Route Number, City t, MD 20	or Town, State, 2	Zip Code)
Baltimore,	Pages 1 arent of Hea nt: If item:		20a. Method of Disposition 1	b. Place of Disponentery, cre t. Leba!	osition (Name of ematory or other pla non Cemet	ce) Day 01/03		Location - City or le1phi,N	
Balti	permit. I Departm Importer eny injui		21. Signature of Fureral Service Licens e	-	orentusky 54 Carrol	osHebrew Fu 1 St., NW,	neral Hom Washingt	ie con, DC	20012
	Physician		23a. Part 1. Enter the disease, or complications that caused the control shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a	e Heart	iter the mode of dyi				Approximate Interval Batween Onset and Death 6 Months
	/Medical Examiner	L.	Due to (or as a con						
D.	be executed sician and burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a con cause (Disease or injury that initiated events cause (Disease or injury that initiated events cause (Disease or injury that initiated events cause or injury that inju		· · · · · · · · · · · · · · · · · · ·				
760,	<u> </u>	cai	d						
.O. Box 68	ath certifica	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of prediction in the past 12 months? 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	□Ectopic pregnanc	у		23d. Date of de Month	livery Day Year
<u>α</u>	uires that the de signed by the a id be detached t	ρχ	Part II. Other significant conditions contributing to death but not Hypertension	resulting in the	underlying cause gr	ven in Part I.			o the cause of death?
Vital Records,		Completed	Atrial Fibrillation				24a. Was an autopsy performed?	prior to death?	utopsy findings available completion of cause of
Vita	Physicien: 1 this certifical ral director, p	o Be	25. Was case referred to medical examiner? 1 Yes 2 X No Hospital: 1 Inpatient	2 ☐ ER/Outpatie	ont 3 DOA Ct	26. Place of Death her: 4 Wursing Home		6 Other (Sou	acifu)
of	ing After une	-	27. Manner of Death 1 X Natural 5 Pending (Month, Day Year 2 Accident investigation		of 28c. Inju		d. Describe how in		iony)
Division	or Attending after death. I Director: After d in by the fune	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury building, etc. (Sp.	At home, farm, soecify)	treet, factory, office	28	of. Location (Street City or Town, St		tural Route Number,
	To the Hospitel or Atte within 24 hours after de To the Funeral Directo completely filled in by the	edical C	29a. Certifier (Check only one) Medical Examiner: On the basis of examiner and manner stated.				at the time, date a	and place, and du	e to the cause(s)
)	Vorthir Comp	M	29b. Signature and title of certifier			se number 28656		nuary 2,	
			30. Name and address of person who completed cause of death Ravi Passi, M.D., 15245 Shad	(Item 23a) (Type	Road, #:	130, Rockvi	11e, MD	20850	
	Sta Regist		31. Date filed (Month, Day, Year) JAN 0 4 2010 A. Registrar's S	ignature fa	New J				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death January 1, 2010 Year Physician/ GLORIA SHERMAN 6:20A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Montgomery Silver Spring Holy Cross Hospital If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔀 F June 19, New York 193772 Yrs 115-30-2711 Director Usual Residence of Decedent filed within 72 nous ence.
tal Hygiene
ed other than "natural", or items 23a or 28a-f show
ed other than "natural", or items 23a or 28a-f show
event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 ☐ No Maryland Montgomery Silver Spring 10e. Street and Numbe 10g. Citizen of What Country? by Funeral 20905 United States of America 18 Locustwood Court Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc 1 ☐ Yes 2 🗓 No 1 Never Married 2 X Married Maryland 21215-0036 Specify: Caucasian 1 ☐ Yes 2 X No Specify: If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Montgomery County 4 Victim Assistant Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) ည marked Mendel Solomon Clara Koster should be and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st.
Department of Heatth ar
Important: If item 27 is
any injury or other trau <u>Allan Sherman, Spouse</u> 8 Locustwood Court, Silver Spring MD 20905 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Judean Memorial Gardens 01/04/2010 Olney, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service Licensee Will 11800 New Hampshire Ave. Silver Spring MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Astrocytoma (CNS Malignancy) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) and I-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 L recal in the past 12 months?
1 Yes 2 No Year Month Dav g Unknown g Unknown signed k Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed this certificate has been sirral director, page 2 should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No 2 XNo 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 1 X Inpatient 2 ER/Outpatient 3 DOA ပ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Medical Certificate: iniury 5 Pending 1 X Natural 1 Yes 2 No 2 Accident Investigation

Box 68760 P.O. Division of Vital Records, e Hospital or Attending Pl 24 hours after death. e Funeral Director: After th filled in by To the Point 24 Vithin 24 To the Point Contract Contract

Baltimore,

3 ∐ Suicide 4 ☐ Homicide	Homicide determined 286. Place of Injury - At nome building, etc. (Specify)		actory, office		(Street and Number or Rural Route Number, wn, State)
(Check 2	☐ Medical Examiner	an: To the best of my knowledge, death occurr : On the basis of examination and/or investigatio Practioner: To the best of my knowledge, death	n, in my opinion, death occurred a	t the time, date	and place, and due to the cause(s) and manner stated.
29b. Signature and ti	tle of certifier		20c License number		29d Date signed (Month Day Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DO

H64588

1500 Forest Glen Road Silver Spring, MD 20910

January 1, 2010

State Registrar

Suganthi Alagarsamy Suganting 31. Date filed (Month, Day, Year) 11. 04 2010 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** Margaret Kathleen Sorensen 1, A^{M} January 2010 1:30 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Genesis Eldercare Spa Creek Center Annapolis Anne Arundel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) NOV • 12, 19 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** Days Hours 333-12-6343 1 □ M 2 🖸 F 88 Nov. T921 Massachusetts **Director** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a State 10b Count 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or Items 23a or 28a-f show the Medical Evantings must be notified at Oro Valley Arizona Pima 1⊠Yes 2□No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 85737 U.S.A. 1825 W. Wimbledon Way Funeral 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 250No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 3 No Specify: White δ Specify: 3√Vidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Secretary Federal Government 12 is marked othar 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Symame) Be Mary Kathleen McGuigan August Jorgensen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Heatth ar Important: If itam 27 is any injury or othar trau Nina Burns/daughter 1825 W. Wimbledon Way Oro Valley, AZ 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2000 remation 3 ☐ Removal from State 1/5/2010 Glen Burnie, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 21. Signature of Juneral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Irchevic Card, song opolly WIN **Physician** /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, by Physician/Medical attending p 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 244 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 certificate 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: Other: wursing Home 5 ☐ Residence 6 ☐ Other (Specify) s after deam. ral Diractor: After this r 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred Certification: Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide crtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier ical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 137936 pleted cause of death (Item 23a) (Type, Print) Drive 7108 31. Date filed (Month, Da 32. Registrar's Signature State park Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death January 4 Day ′ 201Ö^{ear} 4:15A. **Physician** Jenny (aka) Tseng Chin Sih /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Silver Spring Renaissance Gardens at Riderwood Village | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth May 1 24 Hrs. | 8. Date of Birth May 1 24 Hrs. | 8. Date of Birth May 1 24 Hrs. | 8. Date of Birth May 1 24 Hrs. | 8. Date of Birth May 1 24 Hrs. | 8. Date of Birth May 1 24 Hrs. | 8. Date of Birth May 1 24 Hrs. | 8. Date of Birth May 1 24 Hrs. | 8. Date of Birth May 1 24 Hrs. | 8. Date of Birth May 1 24 Hrs. | 8. Date of Birth May 1 24 Hrs. | 8. Date of Birth May 1 24 Hrs. | 8. Date of Birth May 1 24 Hrs. | 8. Date of Birth May 1 24 Hrs. | 8. Date of Birth May 1 24 Hrs. | 8. Date of Birth May 1 24 Hrs. | 8. Date of Birth May 1 24 Hrs. | 8. Date of Birth May 1 24 Hrs. | 8. Date of Birth May 1 24 Hrs. | 8. Date of Birth May 1 24 Hrs. | 8. Date of Birth May 1 24 Hrs. | 8. Date of Birth May 1 24 Hrs. | 8. Date of Birth May 1 24 Hrs. | 8. Date of Birth May 1 24 Hrs. | 8. Date of Birth May 1 24 Hrs. | 8. Date of Birth May 1 24 Hrs. | 8. Date of Birth May 1 24 Hrs. | 8. Date of Birth May 1 24 Hrs. | 8. Date of Birth May 1 24 Hrs. | 8. Date of Birth May 1 24 Hrs. | 8. Date of Birth May 1 24 Hrs. | 8. Date of Birth May 1 24 Hrs. | 8. Date of Birth May 1 24 Hrs. | 8. Date of Birth May 1 24 Hrs. | 8. Date of Birth May 1 24 Hrs. | 8. Date of Birth May 1 24 Hrs. | 8. Date of Birth May 1 24 Hrs. | 8. Date of Birth May 1 24 Hrs. | 8. Date of Birth May 1 24 Hrs. | 8. Date of Birth May 1 24 Hrs. | 8. Date of Birth May 1 24 Hrs. | 8. Date of Birth May 1 24 Hrs. | 8. Date of Birth May 1 24 Hrs. | 8. Date of Birth May 1 24 Hrs. | 8. Date of Birth May 1 24 Hrs. | 8. Date of Birth May 1 24 Hrs. | 8. Date of Birth May 1 24 Hrs. | 8. Date of Birth May 1 24 Hrs. | 8. Date of Birth May 1 24 Hrs. | 8. Date of Birth May 1 24 Hrs. | 8. Date of Birth May 1 24 Hrs. | 8. Date of Birth May 1 24 Hrs. | 8. Date of Birth May 1 24 Hrs. | 8. Date of Birth May 1 24 Hrs. | 8. Date of Birth May 1 24 Hrs. | 8. Date of Birth May 1 24 Hrs. | 8. Date of Birth May 1 24 Hrs. | 8. Date of Birth May 1 24 Hrs. | 8. Date of Birth May 1 24 Hrs. | 8. Date of Birth May 1 24 Hrs. | 8. Date of Birth May 1 24 H 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 1 F China" 85 101-26-4172 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State ed other than "natural", or items 23a or 28a-f show event, the Madical Examiner must be notified at Silver Spring 1 ☐ Yes 2 No Maryland Montgomery Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20904 12309 Loft Lane United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Asian 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Specify: Specify: 3 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within ment of Health and Mental Hygiene. ant: If item 27 is marked other than 'ury or other traumatic event, it a Ma College (1-4or 5+) Elementary/Secondary (0-12) Federal Government Chemist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ven Pin Chow Ven Sih Chow 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2:
Department of Health a
Important: If item 27 Is
any injury or other trae 27 Huntington Drive Danbury, CT 06811 Michael K. Sih -son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Gate of Heaven Cemetery 1/6/2010 SilverSpring, Maryland 4 Donation 5 DOther (Specify) 21. Signature of Funeral Service License Donald V. Borgwardt Funeral Home, PA VVSa 4400 Powder Mill Road Beltsville, Maryland 20705 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Physician 2 years Alzheimers Disease /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed and I-tran Due to (or as a consequence of): physician a 68760, Physician/Medical as Box IF FEMALE: nse 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Live birth 2 Fetal death Ye ar in the past 12 mon Month Day 5 ☐ Other (specify) P.0. the 9 Duknown 9 Unknown by signed the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ANo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2X\ No 24a. Was an this certificate has page 2 s autopsy 1 ☐ Yes 2 **N**Vo Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 1 ∐Yes 2 📆 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28a. Date of Injury (Month, Day, Year) within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1X Natural 5 Pending 2 □No investigation 1 □Yes 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) OTo the I 29d. Date signed (Month, Day, Year)

State Registrar

JAN 05 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title

31. Date filed (Month, Day, Year)



29c. License number

D24093

January 4, 2010

Box 68760. P.0. Records, Hospital or Attending Physician: The law requires Vital Division of 24 hours e Funeral To the I within 24

> State Registrar

29a. Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

JAN 05 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Susan Miller MD 8218 Wisconsin Ave.

32 Registrar's Signature

0

Barked

t 🖰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

#305 Bethesda, MD 20814

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		-	For State ORIGINAL Registrar	Maryland / Depa	rtificate of D			eg. No. 2 [01005
			1. Decedent's Name (First, Middle, Last)				Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic		Betty P. Satzer					ary 02, 2010	11:10 A M
1	Examin		4a. Facility Name (If not institution, give street and nur		4b. City, Town, or L			4c. County of Dea	ith
sel !			Frostburg Village Nursing Care C			Frostburg	9 Data of Birth	Allegany	rthplace (State or Foreign
ı	Funeral Director		218-12-5550 1□M 2 X F	7. Age (In yrs. last birthday) 86 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, March	Year) C	ountry) [aryland
	and	}	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation				10d. Inside City Limits
	Mary F sho	to	Maryland Allegany	Frostburg					1 YYes 2 □ No
	r 28a	Director	10e. Street and Number 340 Allegany Street	et .	10f. Zip Code		10	0g. Citizen of What C	ountry?
	th wit	la [21532-			U.S.A.	
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, its Modical Examinar must but willfad at or other traumatic event, its Modical Examinar must but willfad at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 1 New Widowed 4 □ Divorced 12. Was Dece Armed Fo	2 No	Was Decedent of His If Yes, specify Cuban 1 □Yes 2 Man	panic Origin? (Spe , Mexican, Puerto l Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	
Maryland 21215-0036	2 hou latura lical E	Completed	15. Decedent's Education	16a. Dece	dent's Usual Occupat	tion uring most of worki		16b. Kind of Busines	
218	thin 7 ie. ian "n	nple	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1	-4or 5+) life.	DO NOT use retired)	nnig most er werki	19	annial coming	
21	ed wi	ပ္ပ	12 2	case	worker	18. Mother's Name	(First Middle A	social service	
and	be fil ntal F ed otl	Be	17. Father's Name (First, Middle, Last) Daniel E. Price			Emma M.		naiden damame)	
Ž	hould nd Me mark matic	은	19a. Informant's Name/Relationship (Type. Print)	19b. Maili	na Address (Street ar			, City or Town, State	Zip Code)
≅	nd 2 saith ar 27 is r trau		Wilma Schutz sister		kins Street		tburg	Maryland	
re,	s 1 and 2. of Health a item 27 is		20a. Method of Disposition	20b. Place of Dispo cemetery, cre-	osition (Name of matory or other place)	Date	20c. Location - City of	r Town, State
<u>E</u>	Page nent c ant: If ary or		1 Burial 2 ☐ Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)	State .	Memorial Park		ry 06, 2010	Frostburg	Maryland
Baltimore,	permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other once.		21. Signature of Funeral Service Licensee	2	2. Name and Address Durst Funera		Frost Ave.,	Frostburg, MI	21532
			23a, Part 1. Enter the disease, or complications that of shock, or heart failure. List only one cause on each	aused the death. Do not en	ter the mode of dying	, such as cardiac o	or respiratory arr	est,	Approximate Interval Between
E	Physician		Immediate Cause (Final disease or condition	NGESTIVE	HEART PA	HLURE			Onset and Death
	/Medical		resulting in death) Due to	ON CESTIVE (or as a consequence of):		72 50			
	Examiner	<u>.</u>	Sequentistry list conditions b. Con	CONARY A	RIERY !	CHSENTE			
	ted	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	(or as a consequence of):					
	execur and al-trar	Examiner	that initiated events c	(or as a consequence of):			<u> </u>	<u> </u>	
68760,	tificate be executed g physician and as the burial-transit	edical F	d						
	tificat ng phy as th	ledi							
O. Box	w requires that the death cert s been signed by the attendin should be detached for use a	by Physician/M	in the past 12 months?	nant at time of death 5	☐ Ectopic pregnancy ☐ Other (specify)			23d. Date of d Month	lelivery Day Year
σ.	requires that the been signed by th hould be detache	/ Ph	Part II. Other significant conditions contributing to d	eath but not resulting in the t	underlying cause give	n in Part I.	23e. Did to	bacco use contribute	to the cause of death?
rds	quires an sign						1 □ Ye	es 2□No 3□	Probably 4 Unknown
of Vital Records,	ician: The law rer certificate has bee ector, page 2 shor	Completed					24a. Was a autops perform	sy prior t med? death	autopsy findings available o completion of cause of ?
ita	ysician: is certifica director, p	Be C	25. Was case referred to medical examiner?			26. Place of Deatl		ne)	
γ	dir is	은	1 Yes 2 No Hospital: 1 □	Inpatient 2 ER/Outpatie		4 par Nursing Ho		ence 6 Other (S	pecify)
n	ing P		1 De latural 5 🗀 r criding	of Injury th, Day, Year) 28b. Time of Injury	Work'	?	28d. Describe h	ow injury occurred	
Sio	Attending r death. ector: After by the funer	icati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 28e Place	of Injury - At home, farm, si		′es 2□No	28f Location /S	treet and Number or	Rural Route Number
Division	after a	Certification:		ing, etc. (Specify)	ireet, lactory, office		City or Tow	n, State)	, tarar results runnisting
	Hospita 4 hours Funeral tely filled	ledical C	29a. Certifier (Check only one) 29a. Certifying Physician: To the 2 Medical Examiner: On the and many many many many many many many many	e best of my knowledge, dea pasis of examination and/or iner stated.	th occurred at the time investigation, in my op	ne, date and place, pinion, death occur	and due to the ored at the time, or	cause(s) and manner date and place, and c	as stated. lue to the cause(s)
	To the within 2 To the Complei	Mec	29b. Signature and title of certifier		29c. License	number	2	29d. Date signed (Mo	enth, Day, Year)
			Usethe		026	907	Č	TANK ARY	04 2010
	nes nes		30. Name and address of person who completed cau Histiff Sidhu 935 B	se of death (Item 23a) (Type	6 Pol Cin	mbools	ald v	nt 21	502
	Sta Regist		31. Date filed (JAN) (1 4 2010	se of death (Item 23a) (Type Shop WAIS) Registrar's Signature	Med Carl	TO CAPE I I'M	1		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

4c. County of Death CHARLES 9. Birthplace (State or Foreign WASH • , D • C • 8. Date of Birth 1 (Month, Day, Year) 1 - 1 7 - 1 9 4 3 10d. Inside City Limits 1 ☐ Yes 2 XNo 10g. Citizen of What Country? U.S.A. 14. Race - American Indian, Black, White, etc. SpecifWHITE 16b. Kind of Business/Industry H.U.D. U.S.GOVT. 20c. Location - City or Town, State CLINTON, MD. Approximate Interval Between Onset and Death years 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 2 No 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29d. Date signed (Month, Day, Year) 20602 LACPORT

3. Time of Death

11:30 PM

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

ARNEL CASTILENCE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

12075

32. Registrar's Signature

ELD LING

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] | [] For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** JANUARY 1:00P.M. 2010 Ruth Naomi Sexton /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Reeder's Memorial Home Washington Boonsboro If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 💢 F 82 Director Dec. 4, 1927 220-26-6232 Pennsylvania Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 1 √Yes 2 No Director Maryland Washington Boonsboro 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 141 South Main Street 21713 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify. Specify: White \$ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Nelson Kline Sr. Marie Susan Biddinger Clarence 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) John T. Sexton/son P. O. Box 98, Myersville, Maryland 21773 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Jan.15,2010 Brentwood, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 504 Main Street Ricketts Funeral Home Myersville, MD 21773 23a. Part 1. Enter the disclass complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, in heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final TO THRIVE AILURG Physician Welfer disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** ADVANCED YEARS. DIAM (MO) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕅 No Month Year Day 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ /Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 2 № No 1 ☐ Yes 2 🕽 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit P.O. Box 68760, attending physician for use as the buria the funeral director, page 2 should be detach Division of Vital Records,

28a-f show

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatth and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinations to another traumatic event, the Medical Examinations to another traumatic event, the Medical Examinations to another traumatic event, the Medical Examinations to a continuous to another traumatic event, the Medical Examinations to another traumatic event, the Medical Examinations are a continuous to a continuous traumatic event, the Medical Examinations are a continuous traumatic events.

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within 24 hours a er deat! To the Funeral Director:

State Registrar (Check only

29b. Signature and title of certifier

and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GHAZALA QADIR, 20311 LAPPANS ROAD, BOONSBORO, MARYLAND 301-432-8470 21713

32. Registrar's Signature 31. Date filed (Month, Day, Year) JAN 20 2010 1. pare

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year # M 2010 anuar Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner OSpita 0 albot Memoria Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth g. Birthplace (State or Foreign **Funeral** 1 DM 2 DF Months Days Hours Min OMonth. Day, Year) Director Usual Residence of Decedent show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location the Maryland notified at Director 28a-f 1 X Yes 2 No 10e. Street and Number 10f. Zip Code ò Citizen of What Country? event, the Medical Examiner must be Funeral 23a 6 items ; Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces' Black, White, etc. 6 þ 1 Never Married 2 Married Yes 2 No 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 📈 No Specify: "natural", Completed 3 Widowed 4 Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, the Meany injury or other traumatic event, the Mea Elementary/Şeconday (0-12) College (1-4 or 5+) 15 h MS. Be Maryland 17. Father's Name (First, Middle, Last) (First, Middle, Maiden Surname, 18. Mother's Name မ WAR Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Numbe<u>r, Cit</u>y or Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location City or Town, State cemetery, crematory or other place, ☑NBurial 2 ☐ Cremation 3 ☐ Removal from State 2010 Donation 5 Other (Specify) Star re of Funeral Service Licensee 22. Name and Address of Facility 8 23a. Part 1. Enter th Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Stina day) Medical resulting in death) Due to (or as a consequence of) Examiner Meta Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Jause (Disease of linjury the burial-transi Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Box 68760 as IF FEMALE: nse s, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy atter in the past 12 months?
1 ☐ Yes 2 ☐ No for Month Day Year Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown should 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed Yes 2 X has page 2 certificate 25. Was case referred to medica **Division of Vital** funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) Hospital: 1 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 □ Yes Certificate: 28d. Describe how injury occurred iniury Natural 5 Pending 24 hours after death. Funeral Director: A 2 No Accident
Suicide Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 within 2 only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 3 2010 Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

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32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 01099 State of Maryland / Department of Health and Mental Hygiene 1 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 1;50A M CLAUDE BRUCE SILER, SR. JAN.8,2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CHARLES CO.NUR.&REHAB.CENTER LA PLATA CHARLES 8. Date of Birth 9. Birthplace (State or April 29, 1918 MISSOURI 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 X M 2 □ F 91 523-18-5940 Director Usual Residence of Decedent the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a State 10h County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Exeminar must be notified at LA PLATA MD. Director CHARLES 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? death with 10200 LA PLATA ROAD U.S.A. Funeral 12. Was Decedent Ever in U.S.
Armed Forces?
1 □ Xes 2 □ No USMC
If Yes, Give
Year or Dates: WWII 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc filed within 72 hours after 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: WHITE 2 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) D.C.METRO POLICE DEPT POLICE OFFICER 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) d 2 should be fill the and Mental H Be JESSE WRIGHT SILER **EULAH TABER** ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ELIZABETH SCHOUTEN-DAUGHTER 4130 CLYDE LANE Health a WHITE PLAINS, MD. 20695 Department of Healt Important: If item 2 any Injury or other once. other altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 Burial 2X Cremation 3 Removal from State METROPOLITAN CREMATORY 1-9-2010 ALEX., VA. 22. Name and Address of Facility
RAYMOND FUNERAL SERVICE, P.A.
LA PLATA, MD. 20646 21. Signature of Funeral Service Licensee M00479 PLATA, MD. 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Hear Valvula disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): sician and burial-transit Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death
☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) signed by the a P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, \$ 2**X** No 3 Probably 4 Unknown icate has been si 1 □ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 1 □Yes Division of Vital Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certificately filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide e Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only and manner stated. To the within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HUSSCIN AtimA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

		_	Please	Type or Print AMEND ITH State of Market #18 Per F	nt in E M#20 aryland H G9 (lack In B / ER Depa 1 / Depa 2 / 0	delible H, G899 ertment c 1/2010	ink, En 1/19 Health	sure A /2010, n and M	II Copies WS Iental Hys	s Are Le	gible.		
			Registrar 1. Decedent's Name (First, Middle, Las				uncate	Deau		2. Date of Dea	ath C	710	3. Time of Death	
	Physicia Medic		Bill John		Stins	on				Month January	z 3 20	Year 10	4:20 A M	
	Examin	er	4a. Facility Name (if not institution, give				4b. City, Tow		n of Death			ty of Death		
	Funeral		1726 Howell Road 5. Social Security Number 6. S		e (In yrs. las	st birthday)	Hager If Under 1 Y	ear If Unc	ler 24 Hrs.	8. Date of Birt	Washington Birth 9. Birthplace (State or Foreign			
	Director		213-28-6289 Usual Residence of Decedent	X M 2 □ F	83	Yrs.	Months Da	ys Hour	Min.	(Month, Day July 18	y, Year) 3 1926		ahoma	
	and show	ē	10a. State 10b. County		10c. City,	Town or Loc	eation						10d. Inside City Limits	
	Maryl 28a-f otifie	Director	Maryland Washingt	ton	Hag	erstov	√n.						1 🗌 Yes 2 🗌 No	
	th the 3aor then	alD	10e. Street and Number				10f. Zip Co				10g. Citizen o		untry?	
	ath wi	Funeral	1726 Howe11 Rd.	12. Was Decedent E	ver in U.S.	13. V	2174 Vas Decedent		Origin? (Spe	cify Yes or No-	U.S		ican Indian,	
336	permit. Page 1 and 2 should be fled within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Minportant: If tiem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 If Yes, Give Year or Dates.	No	11	Yes, specify (Cuban, Mexi	can, Puerto	Rican, etc.)		ack, White	e, etc.	
2-0	hours natur dical I	olete	15. Decedent's E (Specify only highest gr	ducation	1		ent's Usual Oc		ast of work	ina	16b. Kind of			
Maryland 21215-0036	within 72 giene. er than ' the Me	Completed	Elementary/Seconday (0-12)	College (1-4 or 5	+)		O NOT use reti				Gove	rnmen	ıt	
pu	e filed tall Hyge of othe	To Be	17. Father's Name (First, Middle, Last)			_		18. Mc	ther's Name	e (First, Middle, Pempera l	Maiden Surna nce GII	ne k		
ryla	ould be d Men marke matic		William David S 19a. Informant's Name/Relationship (7	Stinson		10h Mailia	A.d.d		trici	a Ann Il Route Numbe	Shore	Stato Zin	Cada	
Ma	d 2 sho alth an 27 is ir trau		Patricia A. Stins			l				town Ma				
ore,	e 1 and of Hea fitem rothe		20a. Method of Disposition 1 从Burial 2 ☐ Cremation 3 ☐		20b. Pla	ace of Dispo	sition (Name o	f		Date	20c. Location			
Baltimore,	Page tment tant: I		4 Donation 5 Other (Special	fy)	1	t Have	n Ceme	tery	<u> </u>				Maryland	
Bal	permil Depar Impor any ir once,		21. Signature of Funeral Service Lin							t Haven ve. Hag			ape1 21742	
			23a. Part 1. Enter the disease, or com									I FIA	Approximate	
4	nysician/	S 17	shock, or heart failure. List only o Immediate Cause (Final disease or condition	he cause on each line	exta	W Civ	6 (0	Volu	Vot Se	cular	Disea	est	Interval Between Onset and Death	
	Medical Examiner		resulting in death)	a. Due to (1) as a	conseque	ence of):	100						100	
		Jer	Sequentially list conditions, it any, leading to immediate	b. Due to (or as a	conseque	ence of):	ellyt						107	
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			resulting in death) Last	Due to (or as a	a conseque	ence of):								
760	cate b physi s the b	ledic		d										
89	ath certificate be a attending physicia for use as the bur	an/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			Ectopic pred	nancy			23d. [ate of del	ivery	
Bo	requires that the death cert. been signed by the attendin should be detached for use	Completed by Physician/Medical	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at 9 ☐ Unknown			Other (specif				, n	f lonth	Day Year	
P.O. Box 68760	ed by detack	y Ph	Part II. Other significant conditions of	ontributing to death be	ut not resu	Iting in the u	nderlying caus	e given in P	art I.	23e. Did to	obacco use co	ntribute to	the cause of death?	
ls, l	uires t in sign uld be	q pa								1 🗆	Yes 2 □ No	3 🗆 Pr	robably 4 Unknown	
corc	aw req as bee 2 sho	plet	**************************************							24a. Was	psy	prior to c	opsy findings available completion of cause of	
Re	The la	Соп								1 Yes	rmed?	death?	2 🗆 No	
ţ	sician; certifi rector,	Be o	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:				6. Place of D						
of V	y Phys er this eral di	e: To	27. Manner of Death	28a. Date of injur	ry :	28b. Time of		4 ∟ Injury at		ome 5 🔀 Resid 28d. Describe h			ify)	
on	ending sath. or: Afte he fun	ficat	1 Anatural 5 Pending 2 Accident Investigation		, rear)	injury		work? 1 Yes 2	□No					
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Luneral Director, After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu	Certificate:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined			ne, farm, stre	eet, factory, of	ice		28f. Location (\$ City or Tox		ber or Rur -	al Route Number,	
	Hospita 24 hours Funeral eted filled	Medical	(Check 2 Medical Exam	rsician: To the best of niner: On the basis of ex rse Practioner: To the	xamination	and/or invest	tigation, in my	pinion, death	occurred a	t the time, date a	and place, and o	lue to the c	cause(s) and manner stated.	
	To the within 2 To the comple	Σ	only one) 3 \square Certifying Nur 29b. Signature and title of certifier	se Fractioner. To the	best of my	Kilowiedge, C		ense numbe		se, and due to th	29d. Date sign	ed (Month	, Day, Year)	
			1		-		0	523	23		01-4-	20	10	
	atl		30. Name and address of person who						_	1 01=:				
	Sta	0	Muhammad Waseem 31. Date filed (Month, Day, Year)	MD. 1126			Hagerst	own M	aryla	nd 2174	0	-		
	Registra		JAN 20 2010	Bearing &	1 1	and I	25							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (Figst, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 741 δ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 5645 Brooks Woods Road Lothian Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex **Funeral** 1 M 2 - F Months Hours Min 07/3171969 Washington DC 217-08-2774 40 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City. Town or Location 10d. Inside City Limits 10a. State Director 1 X Yes 2 No Tarrant Texas Grapevine 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 1108 Silver Lake Drive 76051 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: 3 🗆 Widowed 4 🗆 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) 01 Computer Engineer Computers Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Philip M. Taylor Genevieve Booth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Svitlana Taylor Spouse 1108 Silver Lake Drive Grapevine Texas 76051 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1

Burial 2

Cremation 3

Removal from State Atlantic Crematory 01/04/2010 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Signature of Euneral Service License Annapolis, MD 21401 Hardesty Funeral Home P.A. alu 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Year Day ed by the a 9 Unknown ate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 ☐ Yes 2 ☐ No certificate completed filled in by the funeral director, 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Special thers Home Certificate: To 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 24 hours after death. Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 🗌 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29b. Signature and title of cert a ngleed cause of death (Item 23a) (Type, Print) 30. Name and address of person APOLI) MADZIYU

DHMH 17 Rev 7/2009

State

Registrar

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egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** January 2010 \mathbf{v}_{\bullet} Thurmond 4:44 AM Sonia /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert 3820 Leafcrest Court Dunkirk If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 🕱 F 75 Jun 26, West Virginia 1934 Director 230-40-2641 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Me 1. al Examiner must be notified et 1 ☐ Yes 2 X No Director WV Berkeley Springs Morgan 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with USA 25411 Funeral 558 Fairfax Street permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important: If flem 27 Is marked other than "natural" - - - any injury or other traumatic experiments once. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 If Yes, Give 1 ☐ Never Married 2 ☐ Married White 1 ☐ Yes 2 X No Specify: 2 3 ☐ Widowed 4 ☑ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Cleaning Supplies Sales Representative 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ٥ Northcraft Anne Frank Vickroy 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3820 Leafcrest Court Dunkirk, MD 20754 Sus'n Bice (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 01/04/2010 Clinton, MD Lee Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Euneral Service Licenses 22. Name and Address of Facility Lee Funeral Home Calvert, PA Cary J. Owings, MD 20736 8125 Southern Maryland Blvd. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ung cancer men the disease or condition resulting in death) /Medical Due to (or as consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) be executed sician and burial-trans Due to (or as a consequence of) Box 68760. the attending physician Physician/Medical the as IF FEMALE: esn 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy for in the past 12 menths? 1 ☐ Yes 2 ☑ No Month 4□Pregnant at time of death 5 ☐ Other (specify) P.O. 9☐Unknown 9 Unknown ate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 ✓ Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specific Processing Party Section 1) 1 ☐ Yes 2 ☐ No 2 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? To the Hospital or Attending within 24 hours after death.

To the Funeral Director; After 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) January 2, 2010

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State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Signature

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Year)

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31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 Year 6, JANUARY **Taylor** 16:17 Robert Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WMHS - REGIONAL MEDICAL CENTER CUMBERLAND ALLEGANY 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** 1 🗆 M 2 🗆 F Days Hours Month, Day, Year) Mar 13, Yrs Director 1949 MD 217-52-0598 Usual Residence of Deceder 2 should be filed within 72 hours after death with the Maryland that and Mental Hyglene.
27 is marked other than "natural", or items 23a or 28a-f show traumafic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Cresaptown Allegany 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13100 6th Avenue 21502 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 \(\) \(\) \(\) Yes \(2 \) No \(\) If Yes, Give \(1060 \) Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married 1969-1974 1 Yes 2 No Specify: 3 Widowed 4 Divorced white Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) trackman and equip, operator CSX Railroad Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Elizabeth M. Hersh Taylor Robert Lee Taylor, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code permit. Page 1 and 2 sh Department of Health ar Important; If item 27 is any injury or other trau MD 21502 wife 13100 6th Avenue Cresaptown Pamela Taylor 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 KBurial 2 Cremation 3 Removal from State 1/9/2010 Dawson Cemetery Rawlings MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Puneral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on Immediate Cause (Final disease or condition resulting in death) Physician/ Medical ue to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence or). that the death certificate be executed Cause (Disease or linjury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) Pregnant at time of death ed by the detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the pause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy performed Yes 2 2 or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Director: After the 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1 🗌 Yes 2 🗌 No 1 Natural 5 Pending injury Accident
Suicide
Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined after 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 7 29b. Signature and title of certifier 29c, License number D22181 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

WAGONER,

GARY, M.D.,

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

32. Registrar's Signature

925 BISHOP WALSH ROAD, CUMBERLAND, MD 21502

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) OOA M **Physician** Tabler Richard /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Allegany Cumberland Devlin Manor Nursing Home Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number Days Hours **Funeral** Months 1 ☐ M 2 ☐ F Jun 12. 215-34-4851 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State show 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Modical Exertiner munt by multified at 1 ☐Yes 2 ☐ No Cumberland MD Allegany Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with USA 21502 519 Beall Street Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Yes 2 **X**o If Yes, Give Year or Dates: 1 ☐ Never Married 2 【XMarried 1 ☐ Yes 2 ☐ Xio Specify: Specify. Baltimore, Maryland 21215-0036 ò white 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) tal Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Kelly Springfield Tire mail clerk 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) h and Mental H Be Mary Catherine Donahue Tabler Edgar Ione Tabler ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If item 27 is any injury or other trau MD 21502 Cumberland 519 Beall Street wife Donna Tabler 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Commation 3 ☐ Removal from State MD 1/5/2010 Scarpelli Funeral Home, P.A. Cresaptown 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Scarpelli Funeral Home, PA 21. Signature of Foneral Service Ligensee 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock for heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) mostly , Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and physician and the burial-transi Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending pl yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Tectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death Day Year Month in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 ☑ No 1 ☐ Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Medical Certification: To 28d. Describe how injury occurred 28b. Time of Injury Date of Injury (Month, Day, Year) 28a. 27. Manner of Death 5 Pendina 1 🗀 Ratural 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the I within 2. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 1)00 33280 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

nes

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ JANUARY 6 2010 ear 15:32 Carolyn C. Taft Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death ALLEGANY WMHS - REGIONAL MEDICAL CENTER CUMBERLAND 5. Social Security Number 1f Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8, Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2XXF Months Days Hours Min. Director 93 Yrs 130-05-7962 Gate Usual Residence of Decedent show 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location must be notified at Director 10d. Inside City Limits or 28a-f 1 Yes 2 No WV Mineral Fort Ashby 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? , or items 23a Funeral P.O. Box 1120 26719 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Force If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. Completed by 1 ☐ Never Married 2 X Married 1 Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 Tes 2 X No Specify: White "natural", 3 DWidowed 4 Divorced Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry nand Mental Hygiene. 77 is marked other than "r (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Teacher/Counselor Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) .. Page 1 and 2 should be file tment of Health and Mental tant: If item 27 is marked of jury or other traumatic eve ည Garland Albert Crowder Bessie B. Crowder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert A. Taft Box 1120, Fort Ashby, WV 26719 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State permit, Page Department o Important: If any injury or once, 01/11/2010 4 XXDonation 5 ☐ Other (Specify) Morgantown, WV Memoria, Vault 21. Signature of Funeral Service 22. Name and Address of Facility WVU Human Gift Registry Licensee n P.O. Box 9131, Morgantown, WV 26506 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwe Immediate Cause (Final Physician/ monar disease or condition Medical resulting in death) Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami Cause (Disease or iinjury that initiated events oronan ing physician and as the burial-trans resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 Fetal death Pregnant at time of death in the past 12 months? Month Day been signed by the should be detached 9 🔲 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed cate has page 2 s Be မ

Division of Vital Records, P.O. Box 68760 e Hospital or Attending Physician: The Is 124 hours after death. e Funeral Director: After this certificate heleted filled in by the funeral director, page To the Hospital or Atter within 24 hours after de To the Funeral Directo completed filled in by th

						(
					24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ⋈ No
. Was case referred to medical examiner?				26. Place of Death (Ch	eck only one)	
1 ☐ Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatient	з 🗆	DOA Other: 4 \(\subseteq \text{Nursing} \)	Home 5 ☐ Residence 6	Other (Specify)
. Manner of Death 1 Natural 5 Pending 2 Accident Investigatio	28a. Date of injury (Month, Day, Year)	28b. Time of injury	М	28c. Injury at work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury	occurred

29a. Certifie (Check only one ature and title of certifie 29b. Sig

6 Could not be

determined

1 Scertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

7,2010

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year) D23774

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LIVENGOOD, PAUL, M.D., P.O. BOX 1150, FT. ASHBY, WV 26719-1150

28e. Place of Injury - At home, farm, street, factory, office

building, etc. (Specify)

State Registrar

Certificate:

Medical

Accident Suicide

4 Homicide

Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Dupartment of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any lajury or other traumatic event, the Medical Evantinar must be notified at once. Baltimore, Maryland 21215-0036 Physician /Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

	I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time									3. Time of Death			
1	Dolores Mildred Teslik						Jan 4,				2010 Year 8:30		
r	4a. Facility Name (I	a. Facility Name (If not institution, give street and number)					r Location of De	ath	4c. County of			Death	
	12105	12105 Cedarville Road					dywine					ce George's	
	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)					If Under 1 Year Months Days	in. 8. Date o	ate of Birth Month, Day, Year) 9. Birthplace (State or F			nplace (State or Foreign untry)		
	194 22 9599 1 M X F 79 Yrs. Months Days Hours Min. Aug 13,1930 Glews								wshaw,Pa				
	10a. State	10b. County		10c. City,	Town or Lo	cation						10d. Inside City Limits	
5	MD P.G. Br					andvwine		1 □Yes					
ည္	10e. Street and Number 10f. Zip Code 10g. Citizen of What								What Co	untry?			
ᄪ	12105 Cedarville Road					20	613			ed S	tates		
ner	11. Marital Status 12. Was Decedent Ever in U.S. 13.					Was Decedent of I If Yes, specify Cub	Hispanic Origin?	(Specify Yes of	r No-			American Indian, White, etc.	
2	1 Never Marri	1 Never Married 2 M Married 1 TYes 2 M No				1 □ Yes 2 □ψ+φ	Specify:	orto modification	Specify:				
Completed by Funeral Director	3 Widowed	3 Widowed 4 Divorced Year or Dates:							and the same			wille	
ere	(Spec	15. Decedent's Education 16a. Decede (Specify only highest grade completed) (Give ki						vorking	16b. Kind of Bus			industry	
Ē	Elementary/Seco	Elementary/Secondary (0-12) College (1-4or 5+)					•					me Owner	
	17. Father's Name	12 Housewife 17. Father's Name (First, Middle, Last)						18. Mother's Name (First, Middle, Maiden Surname)					
o ne	V	Vincent F. Olszewski					Anna Feldovich						
-	19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town								n, State, Z	Zip Code)			
	William M. Teslik (Husband) 12105 Cedarville Road, Brandywine, MD 2								MD 20	n613			
	20a. Method of Disposition 20b. Place of Disposition (Name of						1	Date 20c. Location - City or Town, State					
	1 □ Burial 2 ⚠ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Lee Crematory Jan 5, 2010 Clinton,								n. M	MD			
	21. Signature of Fu	ineral Service Licen	se /		22	2. Name and Addr	ess of Facility Le	ee Fune	ral F	lome.	inc 6	5633 O1d	
	21. Signatur of Funeral Service Leensee 22. Name and Address of Facility Lee Funeral Home, inc 6633 Old Alexandria Ferry Road, Clinton, MD 20735												
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									Approximate Interval Between Onset and Death			
	Immediate Cause (Final disease or condition A17H2, Wevs D, Serve									Offset and Death			
	resulting in death)												
اي	Sequentially list conditions, Due to (or as a consequence of):												
Examiner	cause. Enter Unde Cause (Disease or	erlying	nce on:										
Xau	Cause (Disease or injury that initiated events resulting in death) Last c Due to (or as a conse				quence of):								
Medical													
anyın	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy					Testania pregnan		23d. Date					
Sicie	in the past 12 months? 1 Pregnant at time of death 5 Other (specify)							Month				Day Year	
Pnys	9 Unknown '												
2	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 🅇 No 3 ☐ Probably 4 ☐ Unknown					
Completed								1 ☐ Yes 2 🌠 No 🤇				Unknown	
n bie							-	autopsy prior			autopsy findings available to completion of cause of		
3									performed? death? 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No				
De	examiner?	A Hospital: Other:											
2	1 ☐ Yes 2 ☐	1 Inpatient 2 EN/Outpatient 3 DOA 4 Nursing Home 5 Hesidence 6 Other (Specify)											
IOI	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28b. Time of Injury 38b. Time of Injury 3b. Time o												
Z Z	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or								nber or Ru	ural Route Number,			
L L	4 Homicide building, etc. (Specify) City or Town, State)												
Medical Certification:	29a. Certifier (Check only (C												
earc	one) and manner stated.						resugation, in my opinion, death occurre			and place	s, and due	to the cause(s)	
≥	29b. Signature and	9b. Signature and title of certifier					29c. License number			29d. Date signed (Mo			
	· Wa	Wolker ! Chrief on				(1)	36 000	3	JANUMY and Fort Washin			4,2010	
			completed cause of		23a) (Type,	Print)	, 1	R.1	E.	- 1./	40.1	de enel	
	31. Date filed (Mon	A Char Year)	14 NNG	rar's Signatu	re	101 40	ingstm	0 - (7-10-1		TH PILA	May a de de de	
	J. Date nied (WOII	JAN 0 6 20	10 Person	A A	Sal	arked							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 Pes, FH G899 1 29 2010 JH State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.2 0

DHMH 17 Rev 1/2001

Stat Registra

Physicia /Medica Examine

Funeral

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 9:55a M Vitkovitsky Tamara January 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 10406 Burnt Ember Drive Silver Spring Montgomeru . Social Security Number 7. Age (In yrs. last birthday) Funeral If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 - M 2 X F Months Days Min. 01/01/1930 Hours Director 577-44-2756 80 Ukraine Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at ould be filed within 72 hours after death with the Maryland Mental Hygiene.

marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland 1 Yes 2 X No Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10406 Burnt Ember Drive 20903 U.S.A 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No 1 Never Married 2 X Married Black, White, etc. þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: If Yes, Give 3 Widowed 4 Divorced Specify: Completed Year or Dates White or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Eugene Baczynsky Wira Pacholuk 1 and 2 should be of Health and Me item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ihor Vitkov<u>itsky - Husband</u> <u> 10406 Burnt Ember Dr., Silver Spring, MD 20903</u> 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a Department of H Important: If ite any injury or ot 20c. Location - City or Town, State St. Andrew Ukrainian Cemetery 1 X Burjal 2 Cremation 3 X Removal from State 4 Donation 5 Other (Specify) 01/05/2010 S. Boundbrook, NJ 22. Name and Address of Facility Hines-Rinaldi Funeral Home. Inc. 21. Signature of Funeral Service L M00709 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between
Onset and Death

1/2 months Immediate Cause (Final Physician/ disease or condition resulting in death) <u>Acute Leukemia</u> Medical Due to (or as a consequence of) [/]Examiner Metastatic Breast Cancer less 6 months Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or de a consequence of) The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) nding physician use as the burial. Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Day Year Pregnant at time of death signed by the a 1 ☐ Yes 2 D 9 ☐ Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, <u> Inflammatory Breast Cancer - 10 years</u> 1 ☐ Yes 2 🗓 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s performed' 2 🗆 No 1 Yes of Vital Hospital or Attending Physician: 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 X No Other: 은 1 Inpatient 2 ER/Outpatient 3 DOA After this 4 Nursing Home 5 X Residence 6 Other (Specify) 27 Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 X Natural 5 Pending Division after death. 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check within 2 29c. License number D35996 10 January 04, 2010 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) Burrell. Linda M. M.D.._University Blvd. #400. Wheaton. Maryland 20902 31. Date filed (Month, I 32 Fegistrar's Signatu State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

	State of Maryland / Department of Health and Mental Hygiene 1- State Certificate of Death Baginary Reg N2 0 0 0 0 0 8 1 1 1 1 1 1 1 1 1											
			Ragistrar		Ce	rtificate	of Death	2. Date of D	Reg. No.	UIU	01100	
	Physici	ian	1. Decedent's Name (First, Middle, Last		1+			Month	Day	Year	3. Time of Death	
4	/Media		4a. Facility Name (If not institution, give	street and number)	gni	4h City Toy	vn, or Location of De	ath		2010 County of Death	0450 AM	
NA.	Examir	ner	Elkton Care	\circ		EIV-	has ma	, and		Leci	1	
	Funeral		5. Social Security Number 6. Se	x 7. Age (In yrs	. last birthday)	If Under 1 Y		rs. 8. Date of B	irth	9. Birth	place (State or Foreign ntry)	
	Director		210-24-8639 10	□M 2 X F	75 Yrs.	Months D	ays Hours N	8. Date of B in. 3/21/	34 Year)	PA	ntry)	
	pu *		Usual Residence of Decedent 10a. State 10b. County	100.0	ity, Town or Lo	- antina					10d Inside City Limits	
	the Marylar 28a-f show notified at	5	,			cation		^			10d. Inside City Limits 1 √ Yes 2 No	
	28a-f	Funeral Director	MD Cecil 10e. Street and Number	E	1kton	10f. Zip Co	<u>.</u>	1-	10g Citis	en of What Cou		
	with le or	Dir	150 E. Main St. A								ritty:	
	ns 23	era	11. Marital Status	12. Was Decedent Ever in t	U.S. 13.	2192. Was Decedent		(Specify Yes or N	US.	4. Race - Ameri	can Indian,	
တ	riter	Fun	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 X No			of Hispanic Origin? Cuban, Mexican, Pu	èrto Rican, etc.)		Black, White,	etc.	
03	rel', c	i by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1⊡ Yes 21√∑	No Specify:			Specify: Whi	ite	
215-0036	within 72 hours after death with the Maryland sne. then "neturel", or Items 23e or 28a-1 show ta Mazical Erectines franst be rodified at	Completed	15. Decedent's Edu (Specify only highest grad	ication le completed)	(Give	dent's Usual O kind of work d	one during most of	working	16b. Kir	d of Business/Ir	ndustry	
121	vithin ne. hen '	ldm	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use re	etired)	•				
121	filed withi Hygiene. other ther		17. Father's Name (First, Middle, Last)		Chef		18 Mother's h	Name (First, Middl		d Servic	ce	
and	1 and 2 should be Health and Mental em 27 is marked of ther treumatic eve) Be	Joseph Phillip Gi	ordono						ouniame)		
Maryland		2	19a. Informant's Name/Relationship (T)		19h Mailir	na Address (St	reet and Number or	r Accrino	_	Town State Zi	n Code)	
S		6 6	James Wright/ son		1		ll Parkwa		_			
ē,			20a. Method of Disposition	20b.	Place of Dispo		of place)	Date		ation - City or T		
Ę	Pages nent of ont: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ F	Removal from State	-		eral Home	5/10 P A	Ris	ing Sun,	MD	
Baltimore,	permit. Pag Department Importent:: any injury conce.		21. Signature of Funeral Service Licens		22	2. Name and A	ddress of Facility			ing Juny	112	
m	Depar Impo any ir		1		R	.T. Foa	ard and Go Main St. I	ee Elkton N	m 210	21		
	Pnysician /Medical Examiner		23d. Part1. Enter the disease, or compleshock, or beart failure. List only o	lications that caused the dea ne cause on each line.	ath. Do not ent	er the mode of	dying, such as card	liac or respiratory	arrest,	, 21	Approximate Interval Between	
6-			Immediate Cause (Final disease or condition	Codrec		rest	_				Onset and Death	
1			resulting in death)	Due to (or as a conse	-		1 0	2 . 1				
		<u>_</u>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (cliebtes of filth)									
		Examiner										
	al-trar	xan	that initiated events resulting in death) Last	c. Due to (or as a conse	quence of):	-						
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Вох	n certi	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregr		7c			2	3d. Date of deliv	ery	
	death	icia	in the past 12 months?	1 Live birth 2 Fet]Ectopic pregn] Other <i>(specif</i>)				Month	Day Year	
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	ysicien: The law requires that the death certificate be executed is certificate has been signed by the attending physician and director, page 2 should be detached for use as the burial-transit	by	Part II. Other significant solutions contributing to death but not resulting in the underlying cause given in Part I.							co use contribute to the cause of death? 2 No 3 Probably 4 Unknown		
ord		ted							Yes 2			
Records,		nple.						24a. Wa	s an	24b. Were auto	opsy findings available ompletion of cause of	
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of	tending Ph death. tor: After th the funeral											
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Division		Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office 28f. Location /						(Street and	Street and Number or Rural Route Number,		
Div	al or A after I Direct	erti	4 Homicide	building, etc. (Specify)					City or Town, State)			
	spits hours inerel y filler		29a. Certifier 1 Certifying Physical Certification Phy	sician: To the best of my kn	owledge, death	occurred at th	ne time, date and pla	ace, and due to the	e cause(s)	and manner as s	stated.	
	To the Hospital or Al within 24 hours after of To the Funerel Direc completely filled in by	edical	(Check only 2 Medical Exami	ner: On the basis of examin and manner stated.	ation and/or in	vestigation, in r	ny opinion, death o	ccurred at the time	, date and	place, and due t	o the cause(s)	
	To t To t	Ž	29b. Signature and title of certifier			29c. Lic	cense number	- /	29d. Date	signed (Month,	Day, Year)	
•			Copores	SUL		De	XCXCV 7	20	1	412		
	j i		30. Name and address of person who co	ompleted cause of death (Ite	m 23a) (Type,	Print)		den (Cot.	Souck	20	
	7		31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature	7 1 1 1		5			7	
	Sta Registr		JAN 0 5		. D	porter	1					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

20 | 0 | 0 | 9 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Physician/ Month 1209 hrs **edical Examiner** Samuel Jeremy White January 11, 2010 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death Baltimore Washington Medical Center Glen Burnie Anne Arundel 5 Social Security Number 6 Sex If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs, last birthday) **Funeral** Months Days 227-43-8790 Director Feb. 17, 1978 1 X M 2 F 31 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits imore, MD 21215-0036
Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at once. Anne Arundel Odenton 1 Yes 2 No Director 10e Street and Number 10f Zip Code 10g. Citizen of What Country? 536 Oakton Road 21113 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S 14 Race - American Indian, Black Armed Forces? White, etc. 1 X Never Married 2 Married 1X Yes Divorced Specify: White , Give Year Iraq 1 Yes 2 X No specify: ۾ 16a, Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Assisted Elementary/Secondary (0-12) College (1-4 or 5+) Living Residence 4 Director 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Edward White Be Robyn Noel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6016 Eastwood Terrace Carl E. White, III/ Brother Norfolk, VA 23508 Jan. 15, 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition 20c. Location - City or Town, State crematory or other place) Burial 2 X Cremation 3 Removal from State Baltimore, MD Department o Metro Crematory, INC. 2010 4 Donation 5 Other Specify. 21. Signature of uneral Service Licenses 22. Name and Address of Facility injury Rarranco & Sons, P.A. 495 Gov. Ritchie Hwy. Severna Park Funeral H Severna Park, MD 21146 Home 23a. Part I. Enter the disease, or complications that caused the death. Oo not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interva Physician failure. List only one cause on each line Between Onset and /Medical Death Fentanyl and cocaine intoxication and methadone use Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical X UNPENDED **AMENDED** signed by the attending physician be detached for use as the burial 23a,PII,27,28a-f,per ME g900 2/4/10 TT Box 68760, IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? P.O. δ 1 Yes 2 No 3 Probably 4 Unknown Complications of myocarditis Completed Division of Vital Records, After this certificate has been sfuneral director, page 2 should 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performed death? 2 No ✓ Yes 2 No 1 🗸 Yes the Hospital or Attending Physician: hin 24 hours after death 25. Was case referred to medical 26.Place of Death (Check only one) funeral director, Be Hospital: 1 Inpatient 2 PER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other 1 Yes 2 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury Certification: Natural neral Director: / 1 Yes 2 X No 5 Pending Fd 1/11/10 Fd 11:17 Investigation Accident 28f. Location (Street and Number or Rural Route Number, City Oder Town, State) 536 Oakton Rd 28e. Place of Injury - At home, farm, street, factory, office building, etc 6 X Could not be Suicide within 24 hours at To the Funeral D determined (Specify) found at residence Homicide 29a. Certifier 1 (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License numbe O.C.M.E. January 12, 2010 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Víctor Weedn MD JD 31. Date filed (Month, State Registrar

DHMH 17 Rev 1/2001

OCME

ORIGINAL

			Please	Type or Print in						
			For State Registrar	State of Marylar		ertificate of L			giene 20 Reg. No.	0 01110
	Division		Decedent's Name (First, Middle, Las	t)				2. Date of Dea	ath	3. Time of Death
	Physicia Medic	al	Irene D.W	110 -1-1				Month	01 2	ear 0305 AM
	Examin	er	4a. Facility Name (if not institution, give	street and number, vendus the Huspith	. 1	4b. City, Town, or	Location of Death		4c. County of I	Death Come rul
	Funeral	9	5. Social Security Number 6. Se	7. Age (In yrs.	last birthday)		If Under 24 Hrs. Hours Min.	8. Date of Birt	h g.	. Birthplace (State or Foreign
	Director		578-52-7072 1 Usual Residence of Decedent	□ M 2 🔭 84	Yrs.	Monaio Bayo	7.100.10	Aug. 17	7, 1925	Sweden
	land show	tor								10d. Inside City Limits
	e Mary r 28a-	Director	Maryland Montgo	omery	Ta	akoma Park	<u> </u>		10 0:4:	1 Ves 2 No
	with th	Funeral	8506 Glenville	Road			912		10g. Citizen of Wha	t Country?
	death items ner m		11. Marital Status	12. Was Decedent Ever in U Armed Forces?	S. 13.	. Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Spe an, Mexican, Puerto	cify Yes or No- Rican, etc.)		American Indian, White, etc.
920	s after 'al", or Examil	d by	1 Never Married 2 Married 3 Widowed 4 X Divorced	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates.		1 ☐ Yes 2 🗷 No	Specify:		Specify:	White
Maryland 21215-0036	2 hours "natur sdical	Completed	15. Decedent's Ed (Specify only highest gra	ducation		edent's Usual Occup e kind of work done o		na I	16b. Kind of Busin	ess Industry
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д 2	filed wall Hygi dother	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name		Maiden Surname)	
<u>ya</u>	should be file n and Mental I 7 is marked o raumatic eve	잍	Sven Grunberg					nknown 		
Ma	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show amy injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (T) Gary C. Verest/So		19b. Mai 80	ling Address (Street 6 Castle 1	and Number or Rura Road, Gle	n Burni n Burni	e, MD 210	, Zip Code) 6 I
altimore,	e 1 and 2 s of Health of item 27 or other tra		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐	Removal from State	Place of Disp cemetery, cre	position (Name of ematory or other place	(ec	Date	20c. Location - Cit	
Ę	it. Page rtment rtant: njury c		4 Donation 5 Other (Specif	"		ematory or other place litan Cres		an. 4, 2010		ia, Virginia
Ba	Depar Impor any ir		21. Signature of Funeral Service Licens	ian		Francis Francis 500 Univ	ቻ°୯ở୩1ins ersity Bl	Funera	l Home In Silver S	c. pring,MD 20901
			23a. Part Unter the lisease, or comp shock, or heart failure. List only of	plications that caused the dea	th. Do not en	iter the mode of dyin	g, such as cardiac c	or respiratory arm	est,	Approximate Interval Between
-	hysician/ Medical	1	Immediate Cause (Final disease or condition resulting in death)	a. Fsche		ent Disco	S-9			Onset and Death
	Examiner		resulting in detail)	Due to (or as a consec						
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3876	rtificate ing phy e as th	/Med	IF FEMALE:	00-16						
P.O. Box 68760	ath ce attend for use	Completed by Physician/Medic	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	 23c. If yes, outcome of pregn 1 Live Birth 2 Fei 4 Pregnant at time of 	al death 3	Ectopic pregnanc Other (specify)	ру		23d. Date o Month	*
о С	requires that the de been signed by the should be detached	Physi	9 L Unknown	9 🗆 Unknown						
ď.	es that signed I be de	l by l	Part II. Other significant conditions of	ontributing to death but not re	sulting in the	underlying cause give	ven in Part I.			te to the cause of death?
ords	requir been s	letec						24a. Was a	an 24b. Were	e autopsy findings available
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ouo	ending sath. or: Afte he fund	ficat	1 Natural 5 Pending 2 Accident Investigation		injury	work	? Yes 2 🗆 No		,	
Division of Vital Records,	or Atte	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Specif		treet, factory, office		28f. Location (S City or Tow		r Rural Route Number,
	spital hours neral I	Medical	29a. Certifier 1 Certifying Phys	sician: To the best of my know	vledge, death	occured at the time	, date and place, an	d due to the cau	use(s) and manner a	s stated.
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Med	only one) 3 . Certifying Nurs	ner: On the basis of examinations Fractioner: To the basis of many of	on and/or inve	, deeth onnumed at th	e time, date and plan	s, and due to the	neumo(s) and manno	
	P w F O		29b. Signature and title of certifier	M.D.		29c. License	47458		29d. Date signed (M	Inth, Day, Year)
	7		30. Name and address of person who o	completed cause of death (Iter	n 23a) (Type,	Print)				
	and the same	NI O	31. Date filed (Month, Day, Year)	3. Registrar's Signa	GOO C	erroll Ave	Takon	u Perk	Maryl	and 21912
	Star Registra		IAN 05 201	Hegistrar a Signa	1 6	. 1. 9				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Date of Death
 Month 3. Time of Death **Physician** Day Year Richard Charles Wengert /Medical 3 2010 January 7:30 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death 12548 Richfield Avenue Corriganville Allegany 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 10/26/1955 9. Birthplace (State or Foreign Country) Maryland **Funeral** 1 € M 2 🗆 F Months Days Hours Mir 54 Director 220-68-6007 Usual Residence of Decedent 10a. State 10b. County ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director MD Allegany Corriganville 1 ☐ Yes 2 ▼No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12548 Richfield Ave, P.O. Box 265 21524 USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 ☐ No 1975 — I Yes, Give Year or Dates: 1977 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: if tem 27 is marked other than "natural", or iten any injury or other traumatic event, the Madical Exp. nitrations. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify ð Specify. 3 Widowed 4 Divorced White 1977 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Construction 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) George (NMN) Wengert Anna Lorraine Bennett ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Belinda Fetters/ Friend P.O. Box 282, Corriganville, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Cumberland Crematory 01/04/2010 4 ☐ Donation 5 ☐ Other (Specify) Cumberland, MD 21. Sign sture of Funeral Service 22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause and line. Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical to (or as a consequence of) Examiner tre Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of) P.O. Box 68760, physician Physician/Medical the as attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown signed I Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 ¥Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has page 2 s autopsy performed? Yes 2 No certificate 1 □ Yes funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Tes 2 No Other: 4 \sum Nursing Home Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 5 Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 24 hours after deat Funeral Director: filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) within 2 the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of

31. Date file I Mo

Bever/ly

person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Calkins, M.D.,

D0054411

600 Memorial Avenue, Cumberland, MD

January 4, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Day 2010 Maggie F. Wright 3 12:30 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Brighton Gardens Columbia Howard 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 3/20/1926 Birthplace (State or Foreign Country) **Funeral** 1 | M 2 | F Months Days Hours Min. 410-34-9382 83 Director TN Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MDHoward Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 7110 Minstrel Way 23a 21045 United States filed within 72 hours after death Funeral items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married ,o Baltimore, Maryland 21215-0036 1 □Yes 2 No If Yes, Give Year or Dates Specify þ 3 ☐ Widowed 4 ☑ Divorced Specify: 'natural", White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Teacher Education 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be 1 Health and Mental Henry Puckett Eura Givens ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cynthia Fagan - Daughter <u>2224 Daisy Rd.</u> Woodbine, MD 21797 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 Hermitage Mem. Gdns 4 ☐ Donation 5 ☐ Other (Specify) 01/07/2010 Hermitage, TN 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family F.H. Inc. M01411 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Alzheimer's Disease Years disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate caus. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Day Year 5 ☐ Other (specify) the 9 Unknown cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 1 certificate 1 □ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 MOther (Specify) Assisted 1 Tes 2 No this Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death Living After t 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1X Natural 2 Accident 1 □ Yes 2 No s after death 3 ☐ Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide hours a within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M.D. January 4, 2010 D56531 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Harry Li 8600 Snowden River Pkwy #301, Columbia, MD 21045 31. Date filed (Month 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

PARLAND.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2:00 A M Eva Mae White January 12, 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany 608 N Fourth St. LaVale, MD If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | Apr. 12, Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months 1 ☐ M 2 🕱 F Charleston, WV 234-28-8448 87 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 28a-f show Examiner must be notified at Allegany LaVale 1 ☐ Yes 2 X No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 608 N Fourth St. 21502 items 23a U.S.A. Funeral Pages 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 'natural", or ğ 1 ☐ Yes 2 ☐ No Specify. White Specify: 3 Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Health and Mental Hygiene. em 27 is marked other thar Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ္ Guy Bond Chole (Jacques) Bond 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i other tra Dina Wilson 608 N. Fourth St., LaVale, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cunningham Mem Park Jan 18 2010 St. Albans, WV ^{22. Name and Address of Facility} Hafer Funeral Service, P.A. 1302 National Highway, LaVale, MD 21502 21. Signature of Euneral Service Licenses 23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 4 CAR /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lissass of Injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attendion abusinan and physician and s the burial-trans Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical attending ph for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnapt 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mon 5 Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an performe 1 □Yes 2 1NO 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation ours after death.

neral Director: /
filled in by the for 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD, 925 BISHOP WALSH DR., CUMBERLAND, MD 21502 GARY WAGONER

Registrar
DHMH 17 Rev 1/2001

State

32. Registrar Signature

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year NANCY JEAN WALTHER January 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick Memorial Hospital Frederick Frederick 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, Yo Ianuary 24 1 □ M 2 🗓 F Days Hours Min Months **Director** 577-42-3806 78 Pennsvlvania Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🗓 No Maryland Frederick Frederick 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? ed other than "natural", or items 23a or event, the Medical Examiner must be in Funeral 5955 Quinn Orchard Road #120 21704 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married δ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 3 X Widowed 4 □ Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry
United States Governmnt. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Printing Office Dispersing Agent is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Dale Mummert Viola Hettrick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health a item 27 i Daniel Walther / Son other i <u>3609 Melinda Court, Monrovia, Maryland 21770</u> Baltimore, 20a. Method of Disposition
1 □ Burial 2 ☒ Cremation 3 □ Removal from State permit. Page 1 a
Department of H
Important: If ite
any injury or otl 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory | Jan. 13, 2010 | Smithsburg, Maryland 21. Signature of Funeral Service Ligenses Meeney and Basford PA Funeral Home, 106 E. Church Street, Frederick, Maryland 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. East only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CoRoway Due to (or as a consequence of): disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last inding physician and use as the burial-trar Due to (or as a consequence of): Physician/Medical or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No Por 4 ☐ Pregnant at time of death 9 ☐ Unknown Day Year the i 9 Unknown ed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? þ Records, SYNDROME MYELODYS PLASTIC 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s Jas autopsy death? certificate 1 ☐ Yes 2 █ No 1 Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗷 No 1 🗌 Yes မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident n 24 hours after death. e Funeral Director: Aft bleted filled in by the fur Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor **To the Fune** completed fi 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) mekon 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9 650 THOMAS VOWNON DRIVE FREDERICK. MO ZI A. DONELSON, MO 31. Date filed (Month, Day, Year)

JAN 20 201 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND TIEM# 20b, perFH, 6899, 1/2072010, WS

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2010 01 /Medical 4a. Facility Name (If not Institution, give street and number) 4b. City_Town, or Location of Death 4c. County of Death Examiner ea If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 1 □ M 2 ▼ F 89 214-10 Yrs 558C Director Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show 10h County 10c. City. Town or Location 10d. Inside City Limits 10a. State Examiner must be notified at Virginia Richmond Director 1 Yes 2 No None 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1800 Gaskins Road 23233 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 X No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Completed by Specify: White 3 X Widowed 4 ☐ Divorced event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ira Weddle Grace Fisher item 27 is marked other traumatic ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 si Department of Health an Important: If Item 27 is any injury or other trausonce. Richard L. Waltz, Sr. / Son 5508 Deer Rum Drive, Fort Pierce, Florida 34951 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition January 15 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 2009 **2010** Frederick, Maryland Mount Olivet Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Dicense 22. Name and Address of Facility
Keeney & Basford P.A. Funeral Home M01433 106 East Church Street, Frederick, Maryland 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** 2-1112 17 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner lor Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Month Day Year Division of Vital Records, P.O. q | Unknown 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed this certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ Ño 25. Was case referred to medical 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital or within 24 hours at To the Funeral D 29a. Certifier 1 🖸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) C 115 MID $\mathcal{G}_{.}$ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shah 14 filed (Month, Day, Year) State

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Registrar

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AMEND ITEM#31perDVR, G899, 1/21/2010, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death ^{Day} 2010 JAN. **Physician** 5:30 P M 15, FREDA ANGELOPULOS /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A (HOPKINS) BALTIMORE BAYVIEW MEDICAL CENTER If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 05/27/1923 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Min. 1 ☐ M 2 🖾 F PA Director 217-20-5728 86 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at BALTIMORE X Yes 2 No MD. N/A Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 616 S. RAPPOLLA STREET 21224 Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2∑No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X☐ No WHITE Specify Š Specify: 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 th and Mental Hygiene.
7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) SELF-EMPLOYED GROCERY STORE 12TH 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be EVDOKIA KAKTAKAS ANASTASIOS DRAKOS 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 616 S. RAPPOLLA STREET, BALTIMORE, MARYLAND 21224 Pages 1 and 2 ment of Health a lant: If item 27 is ury or other tra CHRIS ANGELOPULOS/SON 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. 01/20/2010 BALTIMORE, MARYLAND OAK LAWN CEMETERY 4 Donation 5 Other (Specify) 22. Name and Address of Facility CHARLES S. ZEILER & SON, INC. 21. Signature of Funeral Service Licensee March 1 6224 EASTERN AVE., BALTIMORE, MARYLAND Approximate Interval Between Onset and Death 23a. Part 1. Enter the diseas shock, or heart failure. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest only one cause on each line Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 20 5 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed ng physician and as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 5 Other (specify) signed by the a 2 **X** No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed? Yes 2 No this certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only o e) examiner? 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗖 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) After thi funeral 27. Manner of Death 1 Natural 2 Accident 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 ☐ Yes 2 ☐ No death. within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and life of certifier 29c. License number 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a), (Type, Print), 30. Name and address of person 10. ma. 21224 street 280 3 llite 也 31. Date filed (Month, Day, 32. Registrar's Signature State JAN 21 2010 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2 Date of Death 19,2010 Year Physician/ January 9:53 P M Thomas Benjamin Benton Medical 4a, Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Towson Baltimore Gilchrist Hospice Center If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Funeral Months Days Hours December 2,1919 1 X M 2 □ F Marviand 213-16-9955 Director 90 Usual Residence of Decedent show mit. Page 1 and 2 should be filed within 72 hours after death with the Maryland partment of Health and Mental Hygiene. sortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho: injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 Yes 2 Xo Dundalk Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2718 Southbrook Road 21222 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: Specify: White 3 Widowed 4 Divorced Year or Dates 15 Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Public Transportation 9 vears Auto Body Driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Thomas Vincent Benton Edith A. Chenewith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) wife 2718 Southbrook Road, Dundalk, Maryland Constance M. Benton Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Januäry Oak Lawn Cemetery 2010 Dundalk, Maryland 23, 21. Signature of Funeral Service Licensee ²² Name and Address of Facility Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 23a. Part 1. Enter the disease, once implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Dulman Monrie disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Physician/Medical Examine Due to (or as a consequence oi). attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death 2 No io une runeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached q 🗌 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 🔀 Yes 2 □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 🗌 No 1 Tyes Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 🔀 No Other: မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) WO W within 24 hours after death.

To the Funeral Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 A Accident
3 Suicide
4 Homicide injury 5 Pendina 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) and title of certifie 29b. Sign 29c. License number 29d. Date signed (Month, Day, Year) 20 2010 ryni 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MONA Nonco 6701

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State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** January 20, 2010 2:00 A M William Bienert James /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2514 Chilberry Avenue East Harford Joppa 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) 8. Date of Birth **Funeral** Days 1**∑** M 2□ F 70 Yrs Maryland 213-36-6279 February 12,1939 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatth and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examirer must be notified at 1 ☐ Yes 2X No Director Maryland Harford Joppa 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 2514 Cgilberry Avenue East 21085 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces 1XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 years 1 year Marketing & Sales Marine Terminal 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William James Bienert Sr. Ida Veronica McVey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty L. Bienert wife 2514 Chilberry Avenue East, Joppa, Maryland 21085 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State January 25, 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory Baltimore, Maryland 22. Name and Address of Facility.
Connelly Funeral Home Of Dundalk, P.A. 21. Signature of Funeral Service Licensee 7110 Sollers Point Road, Dundalk, MD. 21222 complications that caused the death. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease. Do not enter the mode of dying, such as cardiac or respiratory arrest, Part 1. Enter the disease, o complications that shock, or heart failure. List only one cause on Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 2 \square No P.0. □Yes 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 24☐ No 24a. Was an autopsy performed? Division of Vital 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 1∐Yes 2☑No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier and address of person who completed cause of death (Item 23a) (Type, Print) Upper Chesapake Dr 32. Registra State Registrar

DHMH 17 Rev 1/2001

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Kathleen Byer	

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State of Maryland / Department of Health and Mental Hygiene	U	1 1	1	

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 | 1 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2<u>010</u> Physician/ Month Margaret D. Bowers J<u>anuary</u> 10:02Am M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Towson Balto. 7. Age (In yrs. last birthday) 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year **Funeral** 9. Birthplace (State or Foreign 1 □ M 2**X** F Months Days Hours Min Director 219-28-8645 October 15 Marvland Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location Director 10d. Inside City Limits Sussex Frankford 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 19945 35051 Meadow Drive USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specity Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married ☐ Yes 2 X No If Yes, Give Year or Dates 3 Widowed 4 □ Divorced 1 ☐ Yes 2 X No Specify White Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Edwin T. Busch Madeline Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Brady DTR. 5713 Magie Street Balto. Md. 21225 20a. Method of Disposition
1 🖺 Burial 2 🗌 Cremation 3 🔲 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) Moreland Memorial 1-11-2010 Parkville, Md. Signatur Frank Servic 22. Name and Address of Facility Schimunek Funeral Home 9705 Belair Rd. Nottingham, Md.21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Complications of canus disease or condition months Medical resulting in death) Due to (or as a consequence of). Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Dav Year signed by the a 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by cate has been signated by page 2 should by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page performed? Yes 2 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 X No Hospital: Other: ၉ 1 Yes 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☑ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 8 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 🔲 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number R149194 7,2010 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 M. Charles Grant Towson. MD 21204 32. Registrar Signatu State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Yea 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimor nenes is If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 M 2□ F Months Hours Min Days 26 2-22 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? . Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2[TNO 1 ☐ Yes 2 No 3 ☐ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) rower Elementary/Secondary (0-12) College (1-4or 5+) Laborer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 19a. Informant's Name/Relationship 19b. Mailing Address (Street and Number or Rural Route Number, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Trinity Cemetery 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lice is 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each life. Immediate Cause (Final disease or condition resulting in death) neumonia Due to (o as a consequence of): Scyler ere Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Honknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? 2 🗆 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 2 No 1 | Inpatient 4 Vursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 27. Mannet of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 5 ☐ Pending investigation

1 TYes

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

uachi

2 🔲 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d, Date signed (Month, Day, Year)

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

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Be Completed

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Funeral

Director

should be filed within 72 hours after death with the Maryland nd Mental Hygiene.

marked other than "natural", or items 32a or 20c t charm.

. Pages 1 and 2 should be fill treent of Health and Mental H tant: If Item 27 Is marked oth

: If Item 27

permit. Page Department o Important: If any injury or

Maryland 21215-0036

Baltimore,

P.O. Box 68760

Division or Vital Records,

7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

the burial-tran as attending for use signed by t d be detach page 2 should certificate or Attending Physician:

funeral director, After this death. filled in by

1 ☐ Yes Natural 2 Accident 3☐ Suicide 4 | Homicide

29a. Certifier

(Check only one)

Examiner Physician/Medical Completed by Be Medical Certification: To

within 24 hours after death To the Funeral Director: completely

the Hospital

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

6 Could not be determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2010 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Day Month **Physician** 2029 M Baker 1-arrey Baker

4a. Facility Name (If not institution, give street and number) 12 2010 January /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Randallstown Northwest Baltimore 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Days Months **X**☐M 2☐F Yrs. 10 Director 19 NC 213-34-4872 Usual Residence of Decedent 10a, State 10c. City, Town or Location 10d. Inside City Limits 10b. County or items 23a or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any Injury or other traumatic event, the "tedcal Examiner must be notified at Baltimore MD 1 X Yes 2 □ No Director NA 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21215 Funeral 4038 Hilton Road U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 No Specify: 2 Specify: Black 3 ☐ Widowed 4 ☐ Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) D.J.J. Savage Co. 9th grade Welder 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 Henry Baker Lovie Woolavd 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4038 Hilton Road, Baltimore, Md 21215 <u>Sylvia K. Baker-Wife</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Park 1/16/10 Woodlawn, Md 21. Signature of Funeral Service License March F/H West 4300 Wabash Ave, Baltimore, Md 21215 3a. Part 1. Finter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Cardiac Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Ishemic Sequentially list conditions, if any, leading to influentiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 1 □ Yes 2 □ No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 2 Unknown 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of death? performed' 1 ☐Yes 2 No 1 ☑Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27, Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 ☑ Natural 5 ☐ Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 🖟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Belchis, MD D0056369 January 13 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Deborah Beldis, MD 5401 Old Court Road RandallsTown, MD 21042 Belchis, MD 32. Registrar's Signature 31. Date filed (Month, Day, "Year) State Registrar

DHMH 17 Rev 1/2001

State

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29b. Signature and title of certifier

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32. Registrar's

owth

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) may complete dunmi

29c. License number

063721

29d. Date signed (Month, Day, Year)

01, 17,2010

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BUTHIA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2, Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ S. Bailey Ellen Month 1^{Day} 2010 10:49p% Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 2736 Baker Street If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 1 M 2 X F Months Days Hours. (Month, Day, Year) 17 ٧A 219-56-5047 92 Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland **Funeral Director** must be notified 1 X Yes 2 No Baltimore MD NA 10e. Street and Number 10f. Zip Code 5 10g. Citizen of What Country? 23a 21216 U.S.A. 2736 Baker Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. 5 Completed by 1 Never Married 2 Married Yes 2 X No 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Black "natural" 3X Widowed 4 □ Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Domestic Worker Private 10th grade traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) if Health and Mental ည Maude Harper Moses E. Jackson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1160 East Northern Parkway, Baltimore, Edward Bailey-Son 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State ō cemetery, crematory or other place) 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State = 5 Department c Important: If any injury or Pikesville, Md Druid Ridge 1/21/2010 Donation 5 D Other (Specify) 21. Sign of Funeral Service Lice Marchod Fryns of Welly t 21215 4300 Wabash Ave, Baltimore, 23a. Part 1. Enter the disease, or complication it it solved the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shinck, or help the failure. List only one cause on each line.

Immediate Cause (Final Interval Between Onset and Death Physician/ CVA disease or condition resulting in death) 2 41 Medical Due to (or as a consequence of): **Examiner** Fibrillation Atrial ye ans Sequentially list conditions, Examiner Due to for as a consumence of nding physician and use as the burial-transit years Cause (Disease or linjury AD that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Year Pregnant at time of death 2 No has been signed by the e 2 should be detached g | Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of Din 24a. Was an autopsy death? Yes 2 No 1 ☐ Yes 2 ☐ No Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital 1 🗌 Yes 은 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No death. 2 Accident Investigation Director 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide completed filled in by determined City or Town, State)

Records, Division of Vital 24 hours a

within 2

State Registrar

Medical

29a. Certifier

only one)

29b. Signature and title of certifier

USMANI Registrar's Signa

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

YX Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

DO065440

29d. Date signed (Month, Day, Year)

01, 20,2010

BALTIMORE

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 | State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Baker, 2010 10:30 p^M Robert н. January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Reisterstown Cherrywood Futurecare Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign Funeral New York (Month, Day, Year) 1 🔀 M 2 🗆 F Months Days Hours Min. 94 **Director** 015-03-7237 Nov. Usual Residence of Decedent or 28a-f show se notified at 10a. State 10b. Count 10c. City. Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Yes 2X No Reisterstown MD Baltimore 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? must be Funeral items 23a 21136 U.S.A. 112 Nob Hill Park Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Examiner Armed Forces? Black, White, etc. o, þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: Specify: "natural", Completed 3 Widowed 4 Divorced White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Page 1 and 2 should be filed within ment of Health and Mental Hygiene. ant: If item 27 is marked other tha Offshore Planning Planning 4 Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Baker Jeanette Lamb Daniel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 112 Nob Hill Park Drive Reisterstown, MD 21136 Mrs. Ethel V. Baker permit. Page 1 and 2 Department of Healtl Important: If item 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 9 1 X Burial 2 Cremation 3 Removal from State Reisterstown, Maryland Druid Ridge Cem. injury (4 ☐ Donation 5 ☐ Other (Specify) 1/23/2010 Signature of Funeral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road any Eline Funeral Home Reisterstown, MD 21136 sans 3a. Part 1. Enter the disease, or complications that caused the death, Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death I mediate Cause (Final Physician. 95 cular isease or condition Medical Examiner resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Year 5 Other (specify) Yes 2 No signed by the a d be detached f 9 Unknown g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given In Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Minknown as been signals to should to Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy certificate ha performed? death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No Be (25. Was case referred to medical funeral director, 26. Place of Death (Check only one) 2 No Hospital Other: 1 Yes မြ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: Aft completed filled in by the fur 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 🎾 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: Dn the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year) 20/10 Mules DA7683 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0835 SMIM AVL 2120 T. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death Decedent's Name (First, Middle, Last) 12 Physician/ Medical 4a. Facility Name (if not institution aive 4b. City, Town or Location of Death 4c. County of Death Examiner learca Battimore MO If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 7-24-1920 9. Birthplace (State or Foreign 5. Social Security Numbe 6, Sex 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Months New York Days 1 X M 2 □ F 89 Yrs **Director** 061-18-4645 Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shot any injury or other traumatic event, the Medical Examiner must ha marified at injury or other traumatic event, the Medical Examiner must ha marified at 10b. County 10c. City, Town or Location 10d, Inside City Limits 10a. State Director 1 X Yes 2 D No NY Broome Binghamton 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 13901 United States 20 Newton Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces Black, White, etc 1 Never Married 2 Married δ Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White If Yes, Give WW II 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) 12 years College (1-4 or 5+) Factory Worker Cardboard Company years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 Orville Bronson Della Frisbie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Hazel Bronson (wife) 20 Newton St. Binghamton, NY 13901 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Carroll Crem. In.c 1-16-2010 Hampstead, MD 4 ☐ Donation 5 ☐ Other (Specify) Fun ral 22. Name and Address of Facility ELINE FUNERAL HOME MD 21136 Wayne Osterling 11824 Reisterstown Road Reistertown, disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, adure. List only one cause on each line. Part 1. Enter the shock, or neart for Approximate Interval Between Onset and Death Immediate Cause (Final umo Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine Due to (or as a consequence of) if any, leading to immediate To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Yes 2 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 TYes 2 No Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) မှ 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1. Natural 5 Pending 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide Investigation 6 🗌 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

State

TEMILOLU 31. Date filed (Month, Day, Year)

29b. Signature and title of certifie

(Check

22 SOUTH 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Registrar

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

108381698

29d. Date signed (Month, Day, Year)

JANUARY

BALTIMORE, MD, 21201

29c. License numbe

GREENE ST.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month **Physician** Alfred Neil Brenner 4:20 anuar 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore

| If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Mar. 7, Good Samaritan Hospital N/A 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Year) 1933 76 Maryland Director 219-28-3705 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show other traumatic event, the Medical Exactions rust by notified at 1 XYes 2 □ No Director Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 23a 4523 Parkwood Avenue 21206 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 14. Race - American Indian, Black, White, etc. Armed Forces

1 Types 2 The Street of The St 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify Š Specify: White 3 ☐ Widowed 4 X Divorced "natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) and 2 should be filed wiealth and Mental Hygier Years Steel Company Foreman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Alfred F. Brenner Rose Unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health 5440 Cedonial Avenue Baltimore, MD Wilma Brenner Department of Heal Important: If item 2 any injury or other once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Pages 1 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith Cem 1/23/2010 Raspeburg, Maryland 22. Name and Address of Facility Miller-Dippel Funeral Home, Inc. 6415 Belair Road Baltimore, MD 21206 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or beart failure. List only one cause on each line. Immediate Cause (Final Physician MYOCARDIAI ACUTE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Due to (or as a consequence of): Gequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine law requires that the death certificate be executed burial-trar resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical the attending phase as the IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) signed by the a P.O. 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Tyes 2 No 3 Probably 4 Tunknown page 2 should BONEMAKADO SUPPREDIONELA. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed or Attending Physician: The certificate 1 ☐Yes 2 HNo 2 40 funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No ■Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Natural Natural within 24 hours after death.

To the Funeral Director: A 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one

State Registrar

DHMH 17 Rev 1/2001

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

ANTOSH 31. Date filed (Month, Day, Year)

5601 Loch Raven Boulevard, Baltimore Maryland 21239 32. Registrar's Signature

29c. License number

RESODO

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First Middle Last) Day **Physician** 2010 BUV /A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner **Baltimore** Randallstown Seasons Hospice of Baltimore 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min. Months 1 ☐ M 2 ☑ F Director So. Carolina Mar 7, 1952 214-58-8206 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 28a-f show 1 XYes 2 □ No traumatic event, the Medical Examiner must be notified Director Baltimore N/A Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2 should be filed within 72 hours after death with and Mental Hygiene. 21213 USA 1500 Spring Street Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☐No Specify: \$ Black 3 -Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) **Beauty Parlor** Hair Stylist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Julia Collins **Eugene Collins** ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any Injury or other trau once. 1 and 2 s 4313 Willshire Avenue Baltimore, Maryland 21206 Jacqueline Anderson Date 20c. Location - City or Town, State 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State 01/22/10 Triangle, Virginia 4 ☐ Donation 5 ☐ Other (Specify) Quantico National Cemetery 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Estep Brothers Funeral Service, P. A 1300 Eutaw Place Baltimore, Md 212 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 449 **Physician** /Medical Due to (or as a con squence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) law requires that the death certificate be executed burial-trar Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No ed by the a 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 2 No 3 Probably 4 Unknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy perform certificate 1 ☐ Yes 2 No Hospital or Attending Physician: '24 hours after death.
Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Other (Special Hospital: 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical completely (Check only and manner stated. To the within 2. 29d. Date signed (Month, Day, Year) 29b. Signature and title of cortifier 29c. License number

State Registrar

31. Date filed (Month, Day, Year)

IAN 21 2010

35 28

32. Registrar's Signature

212

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) B

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month Physician January 10:50 am Lee. Barden /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 28 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year Number **Funeral** Hours Days 245-26-6508 1**X** M 2□ F Months Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County or 28a-f show ?7 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Medical Eventions in the Locality of 1 Yes 2 No MD **Funeral Director** Himore. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Mes 2 □ No tives, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname, Father's Name (First, Middle, Last). Be permit. Pages 1 and 2 should be fil Department of Health and Mental I-Important: If item 27 is marked oth any injuy or other traumatic ever once. Mental Barden ပ္ 19a. Informant's Name/Relationship (Type. Print) Daughter rown, State, Zip Code) 19b. Mailing Address (Street and Number or Rural Route Number, City Kandallstown, MD 21133

200 Location - City or Town, State 8912 Harkate V Tikesville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State ☐ Donation 5 ☐ Other (Specify) 21. Signat e of Funera Service Licensee king tress of Pacifity Greene Funeral Services 0 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ACUTE MYOCARDIAL INFARCTION Lour disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner U Ascie COLONARY HETERY DISEASE Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Physician/Medical the IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 🗆 Ectopic pregnancy Year Month Day 5 Other (specify) signed by the a Ö 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 1 Yes 2 No 3 Probably 4 Unknown Completed carcinaino 24b. Were autopsy findings available prior to completion of cause of death? page 2 s autopsy performed? Yes 2 No 1 ☐ Yes 2 No Vital 1 ☐Yes Physician: the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To Division of After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred or Attending 5 Pending investigation 1 Natural after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a

To the Funeral D Hospital 29a Certifier 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical completely (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DZZEYF JANUARY 18, 2016 900 SOUNI CATON AVONUE BALTIMORE MARYLAND 21229 leine I SNIDER

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

A. Acceptance

			Amend #17 & 18	/pe or Print in Black I per FH g900 2/24/ State of Maryland / Dep	n delible Ink. Ensure Dartment of Health and	All Copies A Mental Hygie	re Legible. ene 20 0	01130
			1 - State Registrar		ertificate of Death		ı. No.	0 0 0
	Physicia	an	1. Decedent's Name (First, Middle, Last)	Bucke	S.r.	2. Date of Death Month	Day Year 16 2010	3. Time of Death
- 1	/Medic Examin		4a. Facility Name (If not institution, give st St AGNES HOS	reet and number)	4b. City, Town, or Location of Dea		4c. County of Death	
and the	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthda		(Month, Day,)	(ear) Cqui	
	Director		Usual Residence of Decedent	12		Trucy 11,	1937 100	eryland
	aryland show	'n	10a. State 10b. County	10c. City, Town or	Location		1	0d. Inside City Limits 1 → es 2 → No
	r 28a-f	Director	10e. Street and Number	Dal	10f. Žip Code	109	g. Citizen of What Cou	ntry?
	th with	al D	2623 N.	Hilton St.	21216		USA	
	tems	Funeral	11. Marital Status	Armed Forces?	3. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - Ameri Black, White,	
9036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Eventine must be neitled at once.		1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 □Yes 2 □No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:	1	Specify: B1	ack
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	filed within I Hygiene. other than "ent, the Mes	Com		College (1-4or 5+)	It - Employ	ed 5	reatood	Ketailer
Maryland	be file ntal H ed oth	Be	17. Father's Name (Fix1 Middle Last)	les	18. Mother's IV	ame (First Middle, Ma	aiden Surname)	
Ž	should and Mer is marke	ျှ	19a. Informant's Name/Relationship (Typ	e. Print) 19b. Ma	ulling Address (Street and Number or	Rural Route Number,	City or Town, State, Zi	o Code) 2101/.
, ⊠a	s 1 and 2 soft Health a item 27 is other trau		Jeanette Ro	Dinson 30	33 (5WYARS)	alls the	uy Bulto.	MO
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re	20b. Place of Dis cemetery, commoval from State	position (Name of rematory or other place)	Date 20	oc. Location - City or T	
Iţim	it. Paç irtmen irtant: njury		4 □ Donation 5 □ Other (Specify)	Greenm	22 Name and Address of Pacilin	7/2010 1	Salto .,	MO
Ba	permi Depa Impo any ii		21. Signature of Funeral Service Licets	ray	Joseph L. Ru	33 trune	Bottone,	MD 2126
			23a. Part 1. Enter the disease, or complic shock, or heart failure. List only on	eations that caused the death. Do not e	enter the mode of dying, such as cardi	ac or respiratory arres	st,	Approximate Interval Between
N.	Physician		Immediate Cause (Final disease or condition resulting in death)	MENINGITI	15			Onset and Death DAYS
	/Medical Examiner		resulting in death)	Due to (or as a consequence of):			9	
	P #	ner	Sequentially list conditions, if any, leading to immediate course fail of the course (Disease or injury	Due to (or as a consequence of):				
	executed an and rial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):				
760,	K		d	Due to (or de a consequence en).				
9289	rtificat ing phy a as the	Medi	IF FEMALE:	A-11				
Вох	eath certificate be execu attending physician and for use as the burial-trar	cian/l	23b. Was decedent pregnant in the past 12 months?		3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of deliver Month	very Day Year
P.0.	t the d by the ached	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown				
	The law requires that the death certificate be ate has been signed by the attending physicis page 2 should be detached for use as the bu	Completed by Physician/Medical	Part II. Other significant conditions con ASPIRATION PN		e underlying cause given in Part I.		acco use contribute to acco use contribute to	the cause of death?
COL	w requ	letec				24a. Was an	24b. Were aut	opsy findings available
- Re	The la ate has)Omb				- autopsy perform 1 □ Yes 2*	ed2/ death?	ompletion of cause of 2 No
/ita	ician: Sertific Sector,	Be (25. Was case referred to medical examiner?	ospital:		eath (Check only one)	
of	Physi r this c ral dire		1 Yes 2 No ⊓ 27. Manner of Death	28a. Date of Injury 28b. Time	e of 28c. Injury at	Home 5 Resider	nce 6 Other (Spec	ify)
ion	nding ath. r; Afte e fune	ation	1 Natural 5 Pending 2 Accident investigation	(Month, Day, Year) Injur	y Work? M 1 □ Yes 2 □ No			
Division of Vital Records,	or Attending Physician: after death. Director; After this certific in by the funeral director, I	Certification: To	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Str. City or Town,	eet and Number or Ru State)	ral Route Number,
_	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical Ce	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examir	ician: To the best of my knowledge, deer: On the basis of examination and/o and manner stated.	eath occurred at the time, date and plant investigation, in my opinion, death of	ace, and due to the ca ccurred at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)
	To the within To the compl	Me	29b. Signature and title of certifier		29c. License number	29	d. Date signed (Month	
			M.D		P23748		Jan, 16, 5	1010
			30. Name and address of person who con RAJANI JAGANA, StAl	GNES HOSPITAL, 900	SOUTH CATON AVE	NUE, BALT	MORE MD	21229
	Sta Registi		31. Date filed (Month, Day, Year)		had			
	9		AULU M T SO	U MANUAL O. A	101/50			

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month /Medical County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign
 Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day) **Funeral** Days Hours Min. 1 □ M 2 🗗 F Months Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: (I tem 271s marked other than "natural", or items 322 and any injury or other transmeth. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ⊟Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country's Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 100 1 ☐ Yes 2 ☐ MO Specify þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) • 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be မှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Da 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 21. Signature Funeral Serio 23a. Part V Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Car se (Final disease or o indition resulting in death) **Physician** Vonsmal /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Duir to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Exami burial-tran The law requires that the death certificate be exec Due to (or as a consequence of): Box 68760, attending physician Physician/Medical the as IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ 10 Month Ye aı 5 Other (specify) P.0. the detached 9 Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24a. Was an autopsy performe 1 □ Yes 2 24b. Were autopsy findings available prior to completion of cause of death? certificate has 2 200 1 ☐ Yes Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) 1∐ Yes 2 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မှ After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A 2 Accident filled in by the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title

Registrar

DHMH 17 Rev 1/2001

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signatu

Edelma

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January19,2016 Margaret Α. Czaja 11:05 P™ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Washington Med. Ctr. Glen Burnie Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year I If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min June13Director 216-14-7771 85 T924 Maryland Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director 1 Tes 2 No Anne Arundel Gambrills Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a or Funeral 2605 Chapel Lake Drive, Unit212 21054-1682 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. Completed by 1 XNever Married 2 Married 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: "natural", 3 Divorced 4 Divorced White Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. $\begin{array}{c} \text{Elementary/Seconday (0-12)} \\ 12\,t\,h \end{array}$ College (1-4 or 5+) Production Electric Western Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Walter A. Czaja Anna 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip $lpha_{ullet}$ 21054permit. Page 1 and 2 sh Department of Health an Important: If item 27 is any injury or other trau once. <u> Eleanor T. Czaja /Sister</u> <u> 2605 Chapel Lake Drive,Unit 212 Gambrills</u> ore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State January 1 🔣 Burial 2 🗆 Cremation 3 🗆 Removal from State Holy Baltim 25, 2010 | Baltimore, Maryland Rosary Cem. 4 Donation 5 Other (Specify) 22. Name and Address of Facility Raczorowski Funeral Rome, PA Signature of Funeral Service Lices 1201 Dundalk Avenue Baltimore, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate nterval Between ns. and Death shock, or heart failure. List only one caus on each line. Immediate Cause (Final Physician, disease or condition resulting in death) Medical u to (or a consequence Examiner 0 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) death certificate be executed physician and the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No Year Pregnant at time of death 5 Other (specify) Month Dav 9 Unknown the g Unknown Hospital or Attending Physician: The law requires that the e detach Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by been signe should be c Records, 1 Yes 2 ho 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an cate has performed 2 1 Yes **Division of Vital** 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 \(\triangle \) Nursing Home \(5 \triangle \) Residence \(6 \triangle \) Other (Specify) 1 Yes 2 No ၉ 1 Inpatient 2 NER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Matural injury 5 Pending 2 Accident
3 Suicide
4 Homicide 1 \sum Yes 2 🗌 No nours after death neral Director: A illed in by the fi Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) 124 hours a Medical Exertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho

To the Fune

completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 only one 29b. Signature a 29d. Date signed (Month, Day, Year) 2009 person who completed cause of death (Item 23a) (Type, Prin Mag State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

avid Clemons	State of Maryland / E			lental Hygien	e 201	0 01133			
Physician/	Reg. No.								
ledical Examiner	David	Cle	mons	Moni Janu	th Day Year Jary 16, 2010	3. Time of Death 2357 hrs			
	4a. Facility Name (if not institution, give street and number) 1638 Chilton Street	4c. County of De	ath						
Funeral		In yrs. last birthday)			te of Birth(MM/DD/YYYY) 9. I	Birthplace (State or eign			
Director	249-56-5226 _{1KM 2 F}	72 Yrs.	Months Days H	lours Min.		Country) S.C.			
á	Usual Residence of Decedent 10a. State 10b. County 10c	c. City, Town or Location	on			10d. Inside City Limits			
daryland 28a-f show any 1 at once. ector	MD na	Baltimor	٠,			1 X Yes 2 No			
the Maryland or 28a-f sh tified at one Director	10e. Street and Number		10f. Zip Code		10g. Citizen of What Co	ountry?			
th the Maryland 23a or 28a-f sho notified at once.	1638 Chilton Street		21218		USA				
or items 23 must be no Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces? 1 Yes 2 X	If Ye	Decedent of Hispanic s, specify Cuban, Mex		etc.) White, etc.				
safter de rall", or niner m	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1	Yes 2 No spe	ecify:	Specify: B]	.ack			
hours hatur Exam	15. Decedent's Education (Specify only highest grade comple Elementary/Secondary (0-12) College (1-4 or 5+)	during mo	s Usual Occupation (C st of working life, DO !		e 16b. Kind of Busines	s/Industry			
5-0036 ed within 72 hour lygiene. other than "natu he Medical Exat	Elementary/Secondary (0-12) College (1-4 or 5+) 10th grade na		eaner		MTA	L			
215-0036 be filed within 7 intal Hygiene. rked other than ent, the Medica Be Comple	17. Father's Name (First, Middle, Last)		18.Mc		Middle, Maiden Surname)				
D 21215-003 should be filed within and Mental Hygiene. 7 is marked other thratic event, the Med To Be Com	Oscar Clarence Clemons 19a. Informant's Name/Relationship (Type, Print)	10h Mailing		etha Gre	eene ute Number, City or Town, Sta	4- 7:- 0-d-)			
ore, MD 21215-0036 s. I and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23s or 28s-fisher traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	Bessie Clemons-Wife		Chilton		Balto, MD				
	20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State	20b. Place of Disposit			20c. Location - City				
Baltimore, oermit. Pages I ar Department of Comportant: If itee injury or other tr	4 Donation 5 Other Specify:	Oaklawn	Cemetery			MD			
Baltimore permit. Pages 1 Department of 1 Important: If injury or other	21. Signature of Funeral Service Licensee				r East F/N nue Balto, N	n 21202			
Physician	23a. Part I. Enter the disease, or complications that caused the					Approximate Interval			
/Medical Examiner	failure. List only one cause on each line. Immediate Cause (Final disease a. Atheroscle	rotic card	iovascular	disease		Between Onset and Death			
Lxammer	or condition resulting in death) Due to (or as a consequence)	ence of):							
ner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of the consequence of	ence of):							
red nisit	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence)	ence of):				-			
ecuted and transition	d								
0, e be execu ysician and burial - tra		PII,27,per	mE, g900 2	/17/10 TT					
Box 68760, the death certificate be executed by the attending physician and the for use as the burial - transit Physician/Medical Exa	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of 1 Live birth		nideath 3 Ec	topic pregnancy	23d. Date of delive Month	ery Day Year			
OX 6 eath ce attend for use	1 Yes 2 No 9 Unknown 9 Unknown	e of death 5 Oth	er (Specify)		_				
O. Bo at the des	Part II. Other significant conditions contributing to death but			in Part I. 236	e. Did tobacco use contribute	o the cause of death?			
s, P.O ires that t signed by d be detac	Diabetes mellitus; chroni	c alcohol	use 	1	Yes 2 ✓ No 3 Pr	obably 4 Unknown			
ords w requ as been s shoul		24a. Was an 24b. We autopsy prid							
Records, The law requires ficate has been sig page 2 should be					performed? death? Yes 2 No 1				
Fital sician: sician: is certification. Be	25. Was case referred to medical examiner? Hospital: 1 Inpatient	2 ER/Outpatient	Othor	ath (Check only one Nursing Home		er Scene			
of V ng Phys after thii meral di	27. Manner of Death 28a. Date of Injury	28b. Time of Inj			scribe how injury occurred				
ttendin tendin death. stor: A / the fu	1 X Natural 5 Pending 2 Accident Investigation		1 Yes 2	2 No	_				
Division of Vital Records, P.O. Box 6876(To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the bedical Certification: To Be Completed by Physician/Me	Suicide Could not be determined (Specify)	- At home, farm, street	, factory, office building		ation (Street and Number or F Town, State)	Rural Route Number, City			
Di Hospital 424 hours a Pfuneral I rely filled	4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my kn	nowledge, death occurre	ed at the time, date and	d place, and due to the	ne cause(s) and manner as st	ated			
To the Howithin 24 h To the Fur completely	one) 2 Medical Examiner: On the basis of examination and manner stated.	ation and/or investigation	nn, in my opinion, deatl	th occurred at the time	e, date and place, and due to	the cause(s)			
Ž	29b. Signature and title of certifier		29c. License num		29d. Date signed (M				
,d	30. Name and address of person who completed cause of death	h (Item 23a)	O.C.M.E.		January 17, 20				
*	Donna M. Vincenti, MD Assistant Medical		Penn Street, Balt	timore, MD 2120)1				
State	31. Date filed (Month, Day, Year) 32. Registrar's S	Signature		· · ·					

DHMH 17 Rev 1/2001 OCME 2006

OCNE

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year 2010 Physician/ CHILDRESS 0023 AM HENRY IANUAN Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner BAUTIMONE JOHNS HOPKINS BAYVIEW MEDICAL CENTER If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🕱 M 2 🗆 F Months 9/17/1957 Mary Iand 52 Director 213-68-9132 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location at 10d. Inside City Limits Director event, the Medical Examiner must be notified 23a or 28a-f 1 Yes 2 X No MD Baltimore Dundalk 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 2216 Searles Road U.S.A. <u> 21222</u> , or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian. Armed Force Black, White, etc. 1 Never Married 2 X Married þ 72 hours after 1 Yes : 2 X No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: and Mental Hygiene. is marked other than "natural", White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Machine Operator Shipping Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Henry Fred Childress, Sr. Ida Evans 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Dora Childress / Wife <u> 216 Searles Rd. Dundalk. MD 21222</u> Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 Other (Specify) Anatomy Gifts Registry 1/21/2010 | Hanover, Maryland 21. Signature of Juneral Service bicens Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Prosician/ CHRONIC OBSTRUCTIVE PULMONMY disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) sician and burial-transit To the Hospital or Attending Physician; T e law equires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months? Month Year Pregnant at time of death Unknown signed by the a d be detached f 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ DIFFETT MELLITUS TIPE II HYPOTENSION 1 Yes 2 No 3 Probably 4 Unknown care has t een sig Completed 24a. Was an Were autopsy findings available prior to completion of cause of 4mp Hom A autopsv performe death? After this certificate Yes Division of Vital 25. Was case referred to medical within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? 2 🗌 No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 욘 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

DHMH 17 Rev 7/2009

State Registr<u>ar</u> Edwara

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

estmoin

82. Registrar's Signature

00028684

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Physician/ Month 5:03 PM January 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Harbor Hospital N/A Baltimore Cit Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) Funeral 9. Birthplace (State or Foreign 1 □ M 2 🖳 F 214-56-6650 Director Country. Yrs 58 1951 Maryland Usual Residence of Decedent show or 28a-f shov notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director N/A Baltimore tyl Yes 2 ☐ No Maryland 10e, Street and Number ò 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with the Oppartment of Health and Mertal Hygiene. Important I flem 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be any injury or other traumatic event, the Medical Examiner must be a Funeral 938 Seagull Avenue 21225 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status was Decedent Ever Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married ρ Baltimore, Maryland 21215-0036 1 ☐ Yes X☐ No Specify: Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry should be filed within 72 hand Mental Hygiene.
7 is marked other than "r (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th grade Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Stafford Gardner Sadie Sewell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 1 2 1 3 Jozella Gilyard/Daughter 2809 E. Federal Street Baltimore, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place, 1/22/10 Lansdowne, Maryland Cemetery! 21. Signature of Funeral Servi 22. Name and Address of Facility Chatman-Harris Funeral Home Turvis 5240 Reisterstown Rd Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ pticemia disease or condition Medical resulting in death) (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examin sician and burial-transit Cause (Disease or imjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð hypertension 1 Yes 2 No 3 Probably 4 Unknown Completed diabetes mellitus type 2 24a. Was an Were autopsy findings available Hospital or Attending Physician: The law page 2 prior to completion of cause of death? Yes 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No 1 Yes Other: ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Maturai 5 Pending work 24 hours after death. Funeral Director: A ☐ Accident Investigation the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and title of cert 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) South Hanover Street Baltimore, Maryland 21225 Brinton 3001

State

Registrar

led (Month, Day, Year

JAN 21 2010

Please Type or Brint in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #7, per FH G899 1/26/10 TT

State of Maryland / Department of Health and Mental Hygiene 2 0 1 1 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 01-18-2010 515 A Kathleen Ann Caprinolo /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Bel Air
| Hunder 1 Year | Hunder 24 Hrs. |
| Months | Days | Hours | Min. | Harford Upper Chesapeake Medical Center Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 □ M 2 🖾 F 212-70-5188 51 01-24-1958 MD Director Usual Residence of Decedent should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10h County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Extractional Extractional and once. 10a. State 1 ☐ Yes 21 No Director MD Harford Jarrettsville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 3902 Belleguard Ct 21084 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 ∏Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married aryland 21215-0036 1 □ Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) RN Medical 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dawn Davis Joseph Mryncza 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3902 Belleguard Ct Gregory T. Caprinolo (Husband) Jarrettsville, MD 21084 Baltimóre, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 01-22-2010 Highview Mem. Gar. Fallston, MD 22. Name and Address of Facility Schimunek Funeral Home of BelAir 21. Signature of Funeral Service Licenses Inc 610 W. MacPhail Rd Bel Air, MD 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician outlet obstruction Gastric disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner cancer melastite OVERREN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Absch L Abdomis Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Dav in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by t 23e Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 1 ☐Yes 2 ☐ No 1 □Yes 2 No Vital 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \(\text{(Specify)} \) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 🗖 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours a er death To the Funeral Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 T Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) 00007452 2010 Mahm MO 10 V 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wijakath moresure 21014 Bul An mo 500 upper chargeens 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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acrinolos

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

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			for State Registrar			,	Ce	rtifica	te of L	Death		101110	Reg. No		IU	UIII	U
	Physicia	an/	1. Decedent's Name	e (First, Middle, La	ast)							2. Date of D		av	Vear	3. Time of Death	
g.	Medi	cal	Eldora					$\overline{}$	stop			Month O1	17			7:35p.	v1
	Examir ,4	ner			ve street and number)			4b. Cit	y, Town, o	r Locatior . t i m			40	. County	of Death		
	Funeral		Joseph 5. Social Security No	umber 6.	Sex 7. Ac	ge (In yrs. la	ast birthday)		ler 1 Year	If Unde	er 24 Hrs.	8. Date of B		Т	9. Birthp	lace (State or Foreig	ın
	Director		212-28-	4004	1 □ м 2 х □ F	79	Yrs.	Month	s Days	Hours	Min.	(Month, D	28 28	30	Count	MD MD	
	and show lat	or	Usual Residence of 10a. State	10b. County		10c. City	y, Town or L	ocation							10	Od. Inside City Limit	s
	Maryla 28a-f	Director	MD	NA		E	Balti	more								1 🔀 Yes 2 🗆 N	10
	an the	al D	10e. Street and Nun					10f. Z	ip Code				10g. Ci		/hat Coun	ry?	
	ath wil	Funeral	1215 We	st Mosh	er Stree		12	Mac Doo		217	wining (Cna	nif . Ven or No			S.A.		
9	er de	by F	1 Never Marri	ed 2 🗆 Married	Armed Forces?							cify Yes or No Rican, etc.)	,		e - America k, White, e		
5-0036	urs aff :ural", al Exa	ted	3x Widowed ⋅		Year or Dates.	•		1 🗌 Yes	2 X No	Specif	y:			Specify:	Bla	ck	
15-	72 ho n "nat ledica	Completed	(Spe	15. Decedent's cify only highest g	Education grade completed)		16a. Dece	kind of w	ork done c		st of worki	ng	16b. K	and of Bu	siness Ind	ustry	
212	vithin giene. er thau		Elementary/Seco		College (1-4 or :	5+)			se retired) aati	.on	Cler	k	Soc	ial	Sec	urity A	dm
п	filed val Hyg	Be C	17. Father's Name (F									e (First, Middle					
yla	uld be I Ment narke	욘	Joseph	Downs			<u> </u>					chard					
Maryland 2121	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Na De ni se		Type,Print) opher Mil	lner	19b. Mail	ing Addre $12~{ m S}$	ss (Street a urbe	and Numb	ber or Rura t • •	Route Numb	er, City or rick	Town, St	ate, Zip C rg	VA 2240	8
$\frac{35}{25}$	of He		20a. Method of Disp		☐ Removal from State		lace of Disp emetery, cre	osition (Na	ame of other plac	e)		Date	20c. Lo	ocation -	City or To	vn, State	
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Bal	permi Depar Impo any ir		21. Signal e Fur	0. /	nsee	- 01	IM.	arch	and Addres	I We	st						
		Н	23a. Part 1. Enter th	ne disease, or cor	mplications that cause	d the death	2V 14	300	Waba	ash	Ave.	Ralt r respiratory a	imor arrest,	e,	Md 2	1215 Approximate	111
2	Physician/		shock, or hear Immediate Cause (f disease or condition	t failure. List only Final	one cause on each line	e.					4	n met		01		Interval Between Onset and Death	U
	Medical Examiner		resulting in death)	•	Due to (or as			7.12	porc	UNC	n con	n mel	61103		7	years	
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. 94	ted J Insit	Examiner	Sequentially list cor if any, leading to in cause. Enter Under Cause (Disease or i	injury	Due to (or as	а согвади	iarioa ciji										
Sperie	executeo an and irial-transi	EX	that initiated events resulting in death) L		C. Due to (or as	a consequ	ience of):								\top		
909	ath certificate be executed attending physician and for use as the burial-transit	Physician/Medical			d										\rightarrow		
Phe 68760	ertifica ding page as	/Me	IF FEMALE: 23b. Was decedent	oroanant	23c. If yes, outcome	of pregnar	ncv										
+c Box	Attending Physician: The law requires that the death certificate be #r death. ector: After this certificate has been signed by the attending physic by the funeral director, page 2 should be detached for use as the bi	icia	in the past 12 n	nonths?	1 ☐ Live Birth 4 ☐ Pregnant a	2 Fetal	I death 3	☐ Ectopic ☐ Other (s		У				23d. Date Mon	e of deliver oth I	y Day Year	
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J 9.	es tha	2	Part II. Other signifi	cant conditions	contributing to death b	out not resu	ulting in the i	underlying	cause giv	ren in Parl	t I.			_		cause of death?	
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Records,	e law e has l	Completed										24a. Was auto	s an opsy formed?	pi de	rior to comeath?	sy findings available pletion of cause of	
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of Vital	nysici nis cer I direc	To B	examiner? 1 Yes 2	No	Hospital: 1	ent 2 🗆 I	ER/Outpatie	nt 3 🗆 [Otho				idence 6	X Other	(Specify)	Hospice	
100	ling Pl		 Manner of Death Natural 	5 Pending	28a. Date of inju (Month, Day		28b. Time o injury		28c. Injury work	?		8d. Describe	how injury	occurre	d		
Sior	Attend death ctor: / y the i	Certificate:	2 Accident 3 Suicide	Investigation 6 Could not I	be 290 Place of Init	ırv - At hor	me farm str	M eet facto		Yes 2	-	Of Leasting	(Ctroot on	nl Alesandra	on Deval	Double Alverton	_
E ldc Division	To the Hospital or Attending Physician: The law requires that the death certi within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendin completed filled in by the funeral director, page 2 should be detached for use.		4 🔲 Homicide	determined	building, etc	c. (Specify)			,			City or To	wn, State)			Route Number,	
	e Hospi 24 hou e Funer	Medical	(Check 2	Medical Exam	ysician: To the best of niner: On the basis of e rse Practioner: To the	xamination	and/or inves	itigation, ir	ı my opinio	n, death c	occurred at	the time, date.	and place.	and due	to the caus	e(s) and manner stat	ted.
	To the within To the comp		29b. Signature and t		\	best of my	Knowledge,		c. License		e and place	s, and due to ti			(Month, D		\exists
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	\mathcal{O}_{l}		30. Name and addre		completed cause of d	eath (Item	23a) (Type, I	Print)	ES 5	τ, :	SHITE	. 416,	BALT	IME	RE, N	ND 21262	+
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DHMH 17 Rev 1/2001

State Registrar

State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day Year Physician 72:18pM 2010 James January /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 9. Birthplace (State or Foreign Country) Northwest anher Ken Itop, ha If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. Months 1**∑** M 2□ F 73 Yrs NC Director 215-30-9190 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modeal Examiner must be notified at 1 □Yes No Director Baltimore Reisterstown MD 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. by Funeral 21136 12020 Reisterstown Road Pages 1 and 2 should be filed within 72 hours after death 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 XNo Never Married 2 ☐ Married "natural", or Baltimore, Maryland 21215-0036 1 ☐Yes 2 X No Specify: Black 3 Widowed 4 Divorced Be Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Brick Cement Co. Construction Worker 10th grade and Mental Hygie is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lucille Hatchery 2 Tom Coley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health a
Important: If item 27 is
any injury or other trau Md 21136 240 Highmeadow Road, Reisterstown, Lucender Leggett-Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/20/2010 Baltimore, On-Site 21. Signature of Funeral Service Licenses March F/H West 4300 Wabash Ave, Baltimore, 23a. Part1. Enter the disease, or complications that be used the shock, or heart value. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death) Approximate Interval Between Onset and Death beused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Form Due to (or as a consequence of): Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed to hours after Apart Apart. Due to (or as a consequence of): P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗆 Ectopic pregnancy Month 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 1. Impatient Certification: To 28a. Date of Injury (Month, Day, Year) neral Director: After the filled in by the funeral 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours after To the Funeral Direct 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier è completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who Rendallsonn mo 2/13) State 31. Date filed (Month. Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** 6:55 AM CHRISTIAN LEONARD, ELLSWORTH, 13 2010 January, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MARDOR MOSPITA N/A Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Number Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, **Funeral** Months **X**□ M 2□ F Yrs Director 213-32-8233 Aug 7, 1937 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 23a or 28a-f show the Medical Examiner must be notified at X ☐ Yes 2 ☐ No Baltimore Directo N/A Maryland 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 2327 Sidney Avenue 21230 U.S.A Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian "natural", or items 11. Marital Status Black, White, etc. ∏Yes 2∏ No f Yes, Give ∕ear or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No þ Specify: Black 3 Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) than, Elementary/Secondary (0-12) College (1-4or 5+) County Ride permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygient Important: If item 27 is marked other the any injury or other traumatic event, the once. Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edna Scott Unknown 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brian Christian 1801 Fallstaff Court Eldersburg, Maryland 21784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State X□ Burial 2 □ Cremation 3 □ Removal from State 01/21/10 Baltimore, Maryland 4 Donation 5 Dother (Specify) Arbutus Memorial Park 21. Signature of Finanti Service Licensee 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217

Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the shock, or hear disease, or complications that caused the deal Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition PNEUMONIA **Physician** 3 dAYS disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 attending physician Completed by Physician/Medical as the IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ⊒Yes 2□No 9□Unknown 9 ☐ Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? STINAL HEMORRHAGE 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an perform 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 은 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Maturai (Month, Day Year) Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No after death 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 🗌 Homicide within 24 hours a To the Funeral I 29a, Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 1/2001

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HAMOUDA

31. Date filed (Month, Day, Year)

JAN 2 1 2010

RESOOO

MD, 3001 South Kanover Street, Baltimore MD, 21225

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Robert Leon Diggs 1 13 2010 10:21 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore na Harford Gardens Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) Social Security Number **Funeral** Months Min. Days 1**∑** M 2□ F 74 5-24-1935 MD 219-32-3778 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the two first Evan in the traumatic event, the two first Evan in the traumatic event, the two first Evan in the first Ev 1 X Yes 2 □ No Director MD Baltimore na permit. Pages 1 and 2 should be filed within 72 hours after death with the I Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a any injury or other traumatic event, Item McIcal Evantics. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21206 U S A 3903 Eirerman Avenue Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status Armed Forces □Yes 2 XNo Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Black Be Completed by 3 Widowed 4 □ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Baltimore City Water Waste 9th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William Shaffer Beatrice Diggs မှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. informant's Name/Relationship (Type. Print) Rosalie Crocker-Friend 3812 Nemo Road Randallstown, MD 21133 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition 1 → Burial 2 → Cremation 3 → Removal from State King Memorial Pk 1-21-2010 Randallstown, 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility March East F/H 21. Signature of Funeral Service Licenses 1101 E. North Avenue Balto,MD 21202 esign a Pay 1. Enter the disease, or complications that caused to that. Do not enter the mode of dying, such as cardiac or respiratory arrest sylck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death maliate Cause (Final Physician disa se or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions r any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine heral Vasylae Disease sician and burial-transit law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) cate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical IF FEMALE ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown 3 Ectopic pregnancy Month Year Day in the past 12 months? 5 Other (specify) ☐Yes 2☐No 9 I Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 9 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 1 No 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **☑** No 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To

P.O. Box 68760. Division of Vital Records, certificate To the Hospital or Attending Physician: i within 24 hours after death.

To the Funeral Director: After this certifica filled in by the funeral

State Registrar

Medical

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28c. Injury at Work?

29b. Signature and title of certifier

5 Pending investigation

6 □ Could not be

29c. License number

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year) 0

28f. Location (Street and Number or Rural Route Number, City or Town, State)

20

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28a. Date of Injury (Month, Day, Year)

woods Road. MD

28d. Describe how injury occurred

31. Date filed (Month, Day, Year)

27. Manner of Death

1 Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

Waldram

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 01-17-2010 Angelo DiFatta 155 Ρ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Baltimore Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 XM 2 □ F Days Hours Min 11-08-1930 Director 219-28-0823 79 Sicily Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County filed within 72 hours after death with the Maryland Director 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 408 S. Tollgate Rd 21014 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates. Completed 3 Widowed 4 Divorced Specify: White 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Barber Hair Styling Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, and Mental F permit. Page 1 and 2 should be 1
Department of Health and Mental Important: If item 27 is many injury or othere. မ Vincent DiFatta Rinaudo Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandy Boggs (Daughter) 2031 Knotty Pine Drive Abingdon, MD 21009 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Date 20c. Location - City or Town, State 1 🗓 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith 01-20-2010 Baltimore, MD 21. Signature of Fureral Service Lin 22. Name and Address of Facility Schimunek Funeral Home of BelAir Inc 610 W. MacPhail Rd Bel Air, MD 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of imjury Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year n signed by the a ld be detached fo 2 No 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by been signatures should be 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2: performe Yes 2 No 25. Was case referred to medica æ 26. Place of Death (Check only one) examiner? Hospital 2 No Other: ျပ 1 🔲 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 D Other (Specify) W 3 7 L W 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation 1 Yes 2 No Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 2 | Medical Examiner: On the basis of examination and of movements and of the cause of examination and of exa within 2 To the 1 only.one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Day, Year) 2303 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year,

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene A 1 = For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 10:10 AM January 201 Kathy Elizabeth Deigert 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number alp rank Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Hours Min 1 ☐ M 2🌠 F Yrs. Maryland Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 No Rosedale Md. Balto. 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 21237 4447 Bucks School House Rd. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? ☐Yes 2 No Yes, Give Never Married 2 Married 1 ☐ Yes 2 No Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) n/a n/a n/a 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Elizabeth Smith Nicholas Deigert 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Rosedale, Md. 21237 4447 Bucks School House Rd. Elizabeth Smith Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation $\overset{X}{\sim}$ 5 ☐ Other (Specify) 1-20-2010 Balto. Md. Bayview 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Schimunek Funeral Home Shumman 9705 Belair Rd. Nottingham, Md,21236 d the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of)

Physician /Medical Examiner

Physician

/Medical

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural; or Items 23a or 28a-f ahow eny lipury or other than "natural; are insufficed as eny lipury or other traumatte event, I'm Medical Examinac mail to anothised as

Baltimore, Maryland 21215-0036

Pages 1

certificate be executed

Division of Vital Records, P.O. Box 68760,

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To the

within 24 hours a To the Funeral L Hospital

burial-transit and ed by the attending physician detached for use as the buria Physician/Medical signed by t Id be detach Medical Certification: To Be Completed by cate has been sig , page 2 should b this certificate within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

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IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy 1	3 ☐ Ectopic pregr 5 ☐ Other (special			23d. Date of delivery Month Day Year						
Part II. Other significant conditions co	ntributing to death but not resulting in th	e underlying caus	se given in Part I.	23e. Did tobacco	ouse contribute to the cause of death? 2 No 3 Probably 4 Unknown						
				24a. Was an autopsy performed?							
25. Was case referred to medical examiner?	26. Place of Death (Check only one)										
1 ☐ Yes 2 No	Hospital: 1 patient 2 ER/Outpa	itient 3 DOA	Other: 4 Nursing H	me 5 Residence 6 Other (Specify)							
27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of Injury 28b. Tim (Month, Day Yeer) Inju		Injury at Work? 1 Yes 2 No	28d. Describe how in	jury occurred						
3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm building, etc. (Specify)	and Number or Rural Route Number, ate)									
	sician: To the best of my knowledge, of iner: On the basis of examination and/of and manner stated.										
29b. Signature and title of certifier		29c. L	icense number	29d. [Date signed (Month, Day, Year)						

State Registrar

d (Month, Day, Year)

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Carolyn Fern Dimeler 2010 January 6:10 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Genesis Healthcare Nursing Home Brooklyn Park Anne Arundel Social Security Numbe 6. Sex 7. Age (In yrs. last birthday) If Under 24 Hrs, Hours Min. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 □ M 2 🛣 F Dec. 21, 1932 Maryland 215-28-3553 Director Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD N/A Baltimore 1 Yes 2 No 10f. Zip Code 21230 10e. Street and Number 2022 Grinnalds Avenue 10g. Citizen of What Country? United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? 1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: If Yes, Give 3 ☐XWidowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Clarence E. Wheatley Laura Unknown permit. Page 1 and 2 should be Department of Health and Men Important. If item 27 is marke any injury or other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2022 Grinnalds Ave., Baltimore, MD 2123019a. Informant's Name/Relationship (Type, Print) Lester J. Dimeler, Jr. Son Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) West Arundel Crematory 1–20–2010 1 Burial 2 X Cremation 3 Removal from State Odenton, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ 000 disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) and I-transit that initiated events resulting in death) Last Due to (or as a consequence of) physician are the burial-t Physician/Medical Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 Yes 2 No Day Pregnant at time of death 1 Yes 2 L 9 Unknown been signed by the should be detached 9 Unknown Part II. Other significant conditions centributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Nnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No has e 2 page certificate 2 No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical Division of Vital funeral director, Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 1 🗌 Yes ည 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifi 29c. License numbe 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month AN 010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1AS 6 Sex 7. Age (In yrs. last birthday 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 M 2 🛭 F Months Hours Min. April 1 Director 218-44-7607 63 1946 Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 No Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 570 Bellerive Road, Apt.112 21409 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces Black. White, etc. "natural", or 1 ☐ Yes 2 ☒ No If Yes, Give 1 Never Married 2 Married Completed by within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White 3 ☑ Widowed 4 ☐ Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hyglene. Important If item 27 is marked other than "naturany injury or other traumatic event, the Medical any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 10 Secretary State of Maryland Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edward Lewis Jackson Elizabeth Tufcona 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jason Dehn Farrara Drive, Odenton, MD 21113 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State Metro Crematory Inc. 4 ☐ Donation 5 ☐ Other (Specify) 2010 Baltimore, Maryland 21. Signature f Furier Service 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause at cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician/ terioselevatic disease or condition resulting in death) BEASK Medical to (or as a consequence of): Examiner Sequentially list condition if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed pidemiA and burial-tran that initiated events Due to (o) as a consequence of): resulting in death) Last attending physician for use as the burial /Medical | Box 68760 IF FEMALE Physician/ 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months? Pregnant at time of death Other (specify) Month Dav Year signed by the a d be detached f 2 🗌 No 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 N 2 🗌 No 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 No 1 Inpatient 2 KR/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? Division 2 🗆 No Accident Investigation Accider
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 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Curtifying Nursus Practicers 1. the last of my knowledge, due to control at the time, date and place, and due to the cause(s) and manner stated 3 Curtifying Nursus Practicers 1. the last of my knowledge, due to control at the time, date and place, and due to the cause(s) and manner stated. (Check 29b. Signature and title of certifier 29c. License number Deput 29d. Date signed (Month, Day, Year) 0605 ess of person who completed cause of death (Item 23a) (Type, Print) ONES State Registrar

10-00438 Donald Ric	chard		n St	pe or Print i tate of Maryl	and / Depar	tment of	Health and		-	Legib	e. 201		0114
			1- For State Registrar		Cert	ificate of	Death 		105	Reg. No			<u> </u>
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Fur	neral		5. Social Security Number	6. Sex	7. Age (In yrs. las	st birthday)	If Under 1 Year	-	24Hrs. 8. Date	of Birth(MN		9. Birthpl Foreign	ace (State or
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Baltimore, permit. Pages 1 ar Department of Hea	mpor		21. Signature of Funeral Service	Licensie		22. N	ame and Address			_			me, P.A.
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Division of Vital Records, P.O. Box 68760, p.d. randing Physician: The law requires that the death certificate be after death.	After this certificate funeral director, page	۱ ا	27. Manner of Death	28a. Dat	e of Injury 2	28b. Time of In	ury 28c. Injury	at Work?	28d. Desc	ribe how in	jury occurred		
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			D. L.	11	P	000	O.C.M				nuary 16, 2		,
		}	30. Name and address of person	who completed car	use of death (Item 2	(3a)	/>						
			Patricia Aronica-Polla		tant Medical Ex		111 Penn Stre	eet, Baltir	more, MD 2	1201			
	St	ate	31. Date filed (Month, Day, Year)	32/F	Registrar's Signature		//						

DHMH 17 Rev 1/2001 OCME 2006

10-00496	
Warren Daugherty	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Varren Daughert		St 1-For State Registrar	ate of Maryla		artment rtificate			d Mental	Hygiene	Reg	20	10	0114
Physiciar Medical Examin	n/	1. Decedent's Name (First, Midd Warren Dent:		2. Date of De Month January			of Death			3. Time of Death 0154 hrs			
		4a. Facility Name (if not institution 707 Clayton Street	on, give street and nu	mber)			y, Town, or I erdeen	Location of D			4c. County of Death Harford		
Funeral Director	- 1	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 167-24-0767 1 M 2 F					nder 1 Year nths Days		_		(MM/DD/YYYY) 1929	Foreign	
auth with the Maryland items 23a or 28a-f show any as be notified at once.	l Directo	Usual Residence of Decedent 10a. State 10b. County Maryland Ha 10e. Street and Number 7 0 7 Clayton 11. Marital Status 1 Never Married 2 MM	10c. City, Town or Location Aberdeen 10f. Zip Code 21001 sedent Ever in U.S. 13. Was Decedent of Hispanic Origination of the specify Cuban, Mexican							10d. Inside City Limits 1 X Yes 2 No nat Country?			
hours afte	mpleted by	3 Widowed 4 Div 15. Decedent's Education (Spe Elementary/Secondary (0-12) 1 2 17. Father's Name (First, Middle,	College (1-	e completed)	16a, Deced during	most of v	al Occupation vorking life.	DO NOT use	,		Specify: W	iness/Ir	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other transmitted.	To Be	Glenn W. Daud 19a. Informant's Name/Relations	gherty hip (Type, Print)				ess (Street	Heler	Geie	e Numbe	er, City or Town,		
lore, MD ges 1 and 2 sho nt of Health and t: If item 27 is other traumati	- 1	Nancy Daugher 20a. Method of Disposition 1 X Burial 2 Cremation	3 Removal fro	20b.	Place of Disp crematory or	osition (N	lame of cem	netery,	Date	Ť	MD 21 Oc. Location - C Aberde	City or 1	
Baltimore, permit. Pages 1 a Department of He Important: If ite injury or other tr	1	4 Donation 5 Other So		щаг	²²	Name a	nd Address	of Facility argo		al	Home,	P. 7	
Physician /Medical Examiner		23a. Part I. Enter the disease, or failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	on each line.	nshot Wou	nd	r the mod	e of dying, s	such as cardia	ac or respirato	ry arrest	, shock, or hear	t	Approximate Interval Between Onset and Death
uted id ransit	Examin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that irritated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): d.											
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Box 68760, te death certificate by the attending physical for use as the burned for use as the burned.	clany	23b. Was decedent pregnant in the past 12 months?	e 1 Live bi	int at time of de	2	Fetal deat Other (Sp	_	Ectopic pre	gnancy	_	23d. Date of d	Da Da	ay Y ear
ires that the signed by I be detach	6	Part II. Other significant conditi	ons contributing to	death but not r	esulting in the	underlyi	ng cause giv	ven in Part I.	23e. 1	_		_	ne cause of death? ably 4 Unknown
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on of Vital ading Physician th. :: After this cer e funeral direct	o L	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pend	Hospital: 1 In	patient 2 of Injury Day Year)	ER/Outpatie 28b. Time o 0142 hrs		DOA C	Other Nu	sing Home	ribe hov	esidence 6 vinjury occurred		Scene
Division o To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral or Attending	Certificat	2 Accident Inves 3 Suicide 6 Could 4 Homicide	tigation 28e. Place	of Injury - At he		eet, facto			or To	wn, State			al Route Number, City
To the Hos within 24 h To the Fur completely	agicai	(Circuit Silly	nysician: To the best niner: On the basis of and manner sta	examination a		ation, in r		death occurre		date and		to the	cause(s)
		30. Name and address of person	·			Pont (O.C.M		ID 21201	J	January 18,	2010	
Stat Registra	2.	Victor Weedn MD JD 31. Date filed (Month, Day, Year)	41	istrar's Signatu		Jenn S		altimore, M					

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year Edmunds Yecolo 200190 9:45 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Hosbi 8) Date of Birth (Month, Day, Year) August 27, 1973 Funeral Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 9. Birthplace (State or Foreign 1 🗆 M 2 🗶 F Hours Min. Maryland 220-94-7874 Director Usual Residence of Decedent or 28a-f shov 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10a. State 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director Baltimore Maryland 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a Funeral 21206 renenaw Ave 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian 1 Never Married 2 Married ş 1 Yes If Yes, Give 2 X No 1 Yes 2 No Specify: Specify: Black Completed 3 Divorced 4 Divorced Year or Dates Baltimore, Maryland 21215-0 injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hyglene. Important: If item 27 is marked other than "any injury or other traumatic event, the Meaone." Elementary/Seconday (0-12) College (1-4 or 5+) ledica Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8747 St 1944 how W. Edmonds Ochlami WicePalrattory 60453 <u> Eionill</u> 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 M Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 20 2010 Battimore, Manyland 4 ☐ Donation 5 ☐ Other (Specify) Name and Address of Facility ture of Funeral Service Licensee Jones 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last rinatod and Due to (or as a consequence of) attending physician for use as the burial Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 →No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has l autopsy death? After this certificate 1 Yes __ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🔲 Yes 잍 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural
2 Accident
3 Suicide 5 \square Pending work? 1 ☐ Yes 2 ☐ No ieral Director: A filled in by the fu Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) within 24 hours a To the Funeral D Medical **Dertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifie (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signature and title of certifier MBBS 00 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Sig State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No Z 0 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month **Physician** 200 AM 2010 Janhery Philip K. Funk /Medical Facility Name (If not institution, give street and number 4c. County of Death 4b. City, Town, or Location of Death Examiner Washington Medical Center Face If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, **Funeral** Months Days Hours 1**∑** M 2□ F 212-30-8277 Director 1935 Maryland FEb 16, Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show event, the Medical Examiner must be notified at Director Anne Arundel Millersville 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 2 301 Hospital Drive 21061 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No U If Yes, Give Year or Dates: , or Items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. unk Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married unk Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔯 No Specify: Specify: white þ 3 Widowed 4 Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) unk 16a. Decedent's Usual Occupation unk 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiene Important: If frem 27 Is marked other tha any Injury or other traumatic event, ITM ORGS. unk unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk Be မှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 301 Hospital Drive Glen Burnie, MD 21061 Baltimore Washington Med Ctr 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burlal 2 ☐ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) in state 21. Signatur, of Funeral Ser Rona 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Director non Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical equence of): Examiner 0 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year ☐ Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 ☐ No been signed by the should be detached 9 I I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>چ</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has trector, page 2 sl 24a. Was an autopsy performed 1 TYes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA this 28b. Time of Injury 28c. Injury at Work? 27. Manner of D th Date of Injury (Month, Day, Year) 28d. Describe how injury occurred After 5 Pending investigation T Natural after death.

Director: Ald in by the fu 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide within 24 hours aft

To the Funeral Di

completely filled in Crtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. the 29b. Signature at 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed ause of death (Item 23a) (Type, Print), 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of Marylan			of Healt of Dea		Mental Hy	giene		0115	1
	Physic /Medi		1. Decedent's Name (First, Middle, L	N. Farrow					2. Date of D	eath Da 15		3. Time of Deat 08 45	
	Exami	ner	4a. Facility Name (If not institution, gi	ve street and number)		4b. City, T	own, or Locat	ion of Death		4c.	. County of Dea	th	
	Funeral Director		5. Social Security Number 6. 225-18-4872 Usual Residence of Decedent	Sex 7. Age (In yrs. 1 M 2 7 8 7	last birthday) Yrs.	If Under 1 Months	Year If Un Days Hou	ider 24 Hrs. Irs Min.	8. Date of Bi (Month, D 3 - 20	irth ay, Year) >- 19	9. Bir Co	thplace (State or Fore buntry) VA	эign
	aryland bhow	_	10a. State 10b. County		y, Town or Lo							10d. Inside City Lin	
	28a-f	ecto	MD Anne A	Arundel	An	napol				10- 00		1 ☐ Yes 2 🔀	No
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960	ours after des el', or Items Examiner	by Funeral Director	11. Marital Status 1 Never Married 2 Married \$\infty \text{Vidowed} 4 \text{Divorced}	12. Was Decedent Ever in U. Amed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		Was Decede If Yes, specif			pecify Yes or No Rican, etc.)	0-	14. Race - Ame Black, White	encan Indian,	
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Maryland	should be and Mental marked o umatic eve	2	John Allen Whit 19a. Informant's Name/Relationship	Ce (Type, Print)	19h Mailir	a Address /			Davis	ner City o	r Town, State, 2	Zin Codo) 21 44	0.2
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Baltimore,	permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other tr once.		20a. Method of Disposition 1 XBurial 2 Cremation 3	Removal from State	lace of Dispo			1	Date		ocation - City or		
Iţim	Pa Int		' 4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Lie	(y) Kin			l Par		.9/10	Woo	dlawn	Md	
Ba	permit. Departn Importa any Inju		Muller N.	Much- VI	Ma	arch	Address of Fa	est	- 7.		e, Md	21215	
	/Medical Examiner	i Examiner	23a. Part1. Enter the disease, or conscious, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence)	uence of):	w	-		or respiratory a	inest,		Approximate Interval Between Onset and Death	
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rds, l	w requires that been signed b should be det	by	Part II. Other significant conditions (contributing to death but not resu	iting in the ur	nderlying cau	se given in Pa	art I.	23e. Did t			the cause of death?	wn
		Completed	25. W						24a. Was autoj perfo 1 ☐ Yes		24b. Were au prior to death?	topsy findings availatements for the completion of cause of the cause	ole of
Ν	Physician: 1 this certifical al director, p	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 → 0	Hospital: 1 ☐ Inpatient 2 ☐ E	R/Outpatien	t 3□ DOA	O.L. &	-	n (Check only o	-	3 □Other (Spec	nife)	
ion of	ding h. After funer	ation; T	27. Manner of Dath 1 Ratural 5 Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	-	Injury at Work?		28d. Describe			any)	
É	p at 2 c	Certification;	3 Suicide 6 Could not b 4 Homicide determined	e 28e. Place of Injury - At hor building, etc. (Specify,	me, farm, stre	eet, factory, o	ffice		28f. Location (: City or Tox	Street and wn, State)	d Number or Ru)	ral Route Number,	
	To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director: completely filled in by the	edicai (29a. Certifier 1 Certifying Ph (Check only one) Medical Exar	nysician: To the best of my knowniner: On the basis of examinati and manner stated.	vledge, death on and/or inv	occurred at estigation, in	the time, date my opinion, d	and place, death occurr	and due to the ed at the time,	cause(s) date and	and manner as place, and due	stated, to the cause(s)	
L	To the To the Comp	Me	29b. Signature and title of defitifier	Cuu		29c. L	icense numbe	1786		29d. Date	e signed (Month	, Day, Year)	
•	h	1	30. Name and address of pason who	completed cause of death (Item		Print)		~	0 (1 1	8/20, 1/6/	0	
	1		31. Date filed (Month, Day, Year)	re 2/08 () Dow	ub (7~ (1	e (for he	W)	2161	9	
	Sta Registr		JAN 2 1 20	32: Registrar's Signat	ha	Red							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** B. Fitzpatrick 1150 PM Joyce Januar 13 2010 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner of Baltimre Sinon Hospital Baltimor If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours Months Days 1 □ M 2**X**□ F 76 Trindad Director 218-78-0246 02 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County important: if item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Profical Examiner must be inclified at 1 ¥Yes 2 □ No Director Baltimore MD NA 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21211 U.S.A. 3518 Greenspring Ave Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 V No Specify. Specify: þ Black ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 1 and 2 should be filed within it Health and Mental Hygiene. College (1-4or 5+) 2yrs Elementary/Secondary (0-12) House Homemaker 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Eloine Harper Brandford Thompson ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, Md 21211 3518 Greenspring Ave, Leslie Fitzpatrick-Daughter 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn 1/23/10 Woodlawn, Md 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, Baltimore, Md 21215 21. Signature of Funeral Service Lic 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Bladder **Physician** Metastate disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any leading to inmediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Live birth 2 Fetal death 3 Ectopic pregnancy Month Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No Ö 9 Unknown <u>م</u> 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Di Jeas 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has b page 2 s autopsy performed certificate 2 No 1 ☐Yes 2 ☐No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Division Hospital or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident Director: 6 ☐ Could not be within 24 hours after dear To the Funeral Directo completely filled in by the 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number KND NES -000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Riven Sipai Hospital of Baltimore and Amadeo

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

ORIGINAL

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 20a, b per fh g899 1-28-10 vt. State of Maryland 7 Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical if not institution, give street and number **Examiner** acation of Death ounty of Death URNI . Age (In yrs. 8. Date of Birth Birthplace (State or Foreign Country)
 OH last birthday) If Under 24 Hrs **Funeral** 1 🕅 M 2 🗆 F 285-38-8955 Months Min 9-14-1940 ОН **Director** Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director MD Anne Arundel Linthicum 1 🗆 Yes 2 🎦 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 503 S. Hammonds Ferry 21090 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: white Completed 3 Widowed 4 X Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Newspaper Proprietor-Delivery Service of Health and Mental Hygie If item 27 is marked other Ir other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Joseph Robert Farrel1 May E. Eary permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr Richard Farrell Jr./son 7 Westminster Dr. Lumberton, NJ 08048 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Bissier & Sous Crem. 1 Burial 2 Cremation State $1/\frac{24}{29}/2010$ Kent, OH 4 Dorlation 5 Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Kirkley-Ruddick 421 Crain Hwy SE Glen Burnie MD Funeral Home PA 21061 M01364 23a. Part 1. Enter the disease, or compilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical for as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): attending physician and for use as the burial-transit VER that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 1 ☐ Yes 2 ☐ 9 ☐ Unknown detached Unknown is been signed by should be detach Other significant conditions contributing to death but not/resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Dleed Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed PANCREATITIS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate has irector, page 2 performed' CIENCI 2 No Yes 2 No 1 Tyes 25. Was case referred to medical Division of Vital funeral director, Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 ☐ Yes 2 Z No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending hin 24 hours after death.

the Funeral Director: Ai

mpleted filled in by the fu 1 Tyes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, RAYMUNDO CAPAREOS) 31. Date filed (Month, Day, Year) Registrar's Signatur State

DHMH 17 Rev 7/2009

Registrar

P.O.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Year FINE GARY M Å M 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner UMMC BAUTIMORE 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**⊠** M 2□ F Months Days Hours Min **Director** 212-42-3035 64 May 15,1945 Virginia Usual Residence of Decedent show 10b. County 10c. City, Town or Location 10d. Inside City Limits or than "natural", or items 23a or 28a-f show Director YYes 2 ☐ No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1115 Nanticoke Street 21230 USA Funeral within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Race - American Indian. 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2XXMarried permit. Pages 1 and 2 should be filed within 72 hours aft. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or i any Injury or other traumatic event, the Medical Examination. Baltimore, Maryland 21215-0036 1 □Yes 2XXVo Specify. þ Specify: white 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) water department Baltimore City 9 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Herbert Fink ဥ Mary Duckins 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Fink-wife 1115 Nanticoke Street, Baltimore MD 21230 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State West Arundel Crematory 1-20-2010 Odenton MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Euneral Service Licensee 22. Name and Address of Facility Ambrose Funeral Home 2719 Hammonds Ferry Road Lansdowne MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** COFD disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause. Unlease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) law requires that the death certificate be executed and burial-trai Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) signed by the a P.O. 1 ☐ Yes 2 ☐ No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by arce as e artery 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy or Attending Physician; The perform certificate 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Yes 2 No Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) (Specify) Certification: To 2 ER/Outpatient 3 □ DOA this 1 Inpatient 28a. Date of Injury (Month, Day, Year) After t 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical completely (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1225246077 2010 e and address of person who completed cause of death (Item 23a) (Type, Print) 5+

State Registrar MOSKOVI 2

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/200

Greene

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32. Registrar's Signatur

Bathmere

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#8perFH, G900, 2/12/2010, WS
State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Year 16,2010 wendolyn aruar /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Edercare Baltimore senesis If Under 1 Year If Under 24 Hrs. 8. Date of Birt March 31,2010.
Hours Min. Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) irthplace (State or Foreign **Funeral** 1□ M 2□ F Days 218-26-9184 Months Director Varyland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 Yes 2 No Completed by Funeral Director ITIMOR 10e. Street and Number Apt 10f. Zip Code 10g. Citizen of What Country 9 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates; 11. Marital Status 12. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Blac Specify: 3 Widowed 4 ☐ Divorced "natural", Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) the L it of Health and Mental Hyg If item 27 is marked other or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be nd Mental and 2 should be ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brother ! Health a permit. Pages 1 ar Department of Heal Important: If item 2 any Injury or other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses dress of Fadility Funtoral Neith Avenue 6 21216 23a. Part / Enter he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Necemon /Medical Due to (or as a consequence of) Examiner aranon Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last mus by Physician/Medical Examiner Due to for as a consequence of The law requires that the death certificate be executed as the burial-transit Due to (or as a consequence of): Box IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 5 Other (specify) Ö be detached signed by the 9□Unknown 9 Unknown ئم Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ ☐ Known Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a, Was an certificate has autopsy performed? Yes 2 No 1□ Yes filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 No Other: 4 Narsing Home 5 Residence 6 Other (Specify) 1 TYes Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Director: After Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a e Funeral I 29a. Certifier 1 Ecritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 021344 6/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ham. 31. Date filed (Month, Day, Year) - -Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JANÜARY 14 **FRANKS** 2010 09:55A DAVID Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 1900 THAMES STREET, #315 BALTIMORE N/A 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Country) MI Hours 1 🕅 M 2 🗆 F *1*73071943 214-42-6730 Director 66 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director 1 X Yes 2 ☐ No BALTIMORE MD N/A 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 1900 THAMES STREET, #315 21231 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 0. 1 Never Married 2 Married Completed by 1 Yes : 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", 3 Widowed 4 Divorced WHITE Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) is marked other than College (1-4 or 5+) 5+ Elementary/Seconday (0-12) **PROFESSOR** EDUCATION Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ MAURICE FRANKS DOROTHY DAVIS and 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 shument of Health ar tant: If item 27 is PAUL FRANKS / SON 26 MAYFLOWER DRIVE, MILFORD, N.H., 03055 20a. Method of Disposition
1 ☐ Burial 2 🗭 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date Department of H Important: If ite any injury or ot 1/19/2010 4 ☐ Donation 5 ☐ Other (Specify) HAMPSTEAD, MD CARROLL CREMATION at e of Fyreral Service Lin 22. Name and Address of Facility SOL LEVINSON & BROS. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complicate shock, or heart failure. List only one ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death ause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Fitter line rhying Cause (Disease or linjury Due to (or as a consequence of): Exami ng physician and as the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical that the death certificate be Box 68760 IF FEMALE for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant a
9 Unknown Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown P.O. | signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, icate has been sig page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform After this certificate 2 [Yes the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 X No ည 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending within 24 hours after death.

To the Funeral Director: Af
completed filled in by the fu Accident Investigation ☐ Accider☐ Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined cai 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medic Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) who completed cause of death (Item 23a) (Type, Print 30. Name and address of person 1120 Ni Rolling Rd Ken 31. Date filed (Month, Day, Year State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ January 12, 2010 8:00 PM M Dorothy Goodman Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Hebrew House of Greater Washington Rockville Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 □ M 2 🔯 F Months Hours Aug 31, Year 906 WEst Virginia 382-12-6822 103 Director Usual Residence of Decedent 28a-f shov 10a. State 10c. City. Town or Location hours after death with the Maryland or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2x ☐ No MD Montgomery Takoma Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7812 Garland Avenue 20912 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc þ 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: white 3

Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working al Hygiene. life. DO NOT use retired Elementary/Seconday (0-12) College (1-4 or 5+) 12 housewife own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked of Phillip Mandel Blanche Leopold 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other traconce. Hebrew House of Greater Washington 6105 Montrose Road Rockville, MD 20b. Place of Disposition (Name of 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4X Donation 5 Other (Specify) Signature of Funeral Service Licer ²² State Arnatomy Board 655 W. Baltimore Street mon Baltimore, MD 23al Part 1. Enter the di, ease, in complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest hock, or heart failure. List only one cause on each line. Approximate CHRONIC Onset and Death Immediate Cause (Final UBSTRUCTIVE PLILHONARY DISENSE Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) attending physician and for use as the burial-transit To the Hospital or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Pregnant at time of death
Unknown Year g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown certificate has been si rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 N 1 🗌 Yes To Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 No Other: 1 Tyes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ☐ Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated H.D. 6121 MUNTROSEROND, ROCKVILLE, MD 20852

State Registrar

P

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21215-0036

Maryland

Baltimore,

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** UBERT S DOCH 2010 30 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** 1820 Maltravers Road Glen Burnie Anne Arundel Co. f Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 8. Date of Birth (Month, Day, Year) 04/16/1932 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1 M 2 □ F Louisiana Director 77 434-30-2030 Usual Residence of Decedent 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits show ral", or items 23a or 28a-f sh Examiner must be notified 1 ☐ Yes 2 74No Director Anne Arundel Co. Glen Burnie MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21060 United States 1820 Maltravers Road Completed by Funeral death 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☑Yes 2 ☐ No 19:
If Yes, Give
Year or Dates: -19 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1951 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔼 No White Specify: Specify: 3 Widowed 4 Divorced -1971'natural", the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) U.S. Navy 12 Chief Petty Officer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic evonce. Mary Bowers Marshall Jack Barnett Gooch ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1820 Maltravers Road Glen Burnie, MD 21060 Mrs. Mary Ann Gooch / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 01/21/2010 | Glen Burnie, Maryland Atlantic Crematory 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Singleton Funeral & Cremation M01121 Services PA; 1 2nd Ave SW; Glen Burnie, MD 21061 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line to the death. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner an Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): attending physician and for use as the burial-transi resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Year Day signed by the a d be detached for 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s autopsy his certificate h 1 ☐ Yes 2 🗆 No 1 ☐ Yes 2 No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 ☐ Yes 2 No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of centifier ted cause of death (Item 23a) (Type, Print) 30. Name and address of person, who con ENTA MO 4 NNA POLIC MICHAEL

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day,

Year)

egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		,	1 - For State Registrar	State of Ma		Certifica			•	giene Reg. No	2010	01159
	Physici	an	1. Decedent's Name (First, Middle, L	.ast) Grant					2. Date of De Month	Day		3. Time of Death
	/Medio		4a. Facility Name (If not institution, g		1	4b. Cit	y, Town, or L	ocation of Death	Januar	-	9 2010 County of Death	07:00 A ^M
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	Funeral			Sex 7. Age	(In yrs. last birt	Month	er 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, D	rth ay, Year)	9. Birth	place (State or Foreign ntry)
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	/land		10a. State 10b. County		10c. City, Town	or Location						10d. Inside City Limits
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	th the	Director	10e. Street and Number				ip Code			10g. Cit	izen of What Cou	ntry?
	ath wi		1225 Dietrich Wa			_	21409				USA	
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2-0	72 hor	sted	15. Decedent's (Specify only highest g	Education	16a.	Decedent's Us	sual Occupati	ion	ina	16b. Ki	ind of Business/In	dustry
7	be filed within 72 ho ttal Hygiene. d other than "natui event, ir Modical	Completed	Elementary/Secondary (0-12)	College (1-4or 5-	+)	life. DO NOT	use retired)	ring most of work	ing			
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	nd 2 salth all		James E. Grant	(Son)	T	•		Colonial				,
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al Kecord	To the Hospital or Attending Physician: The law requires that the death cerwithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use.	Completed							24a. Was auto perfo 1 □Yes		prior to co	opsy findings available ompletion of cause of 2 □ No
VITAL	sician certif rector	Be	25. Was case referred to medical examiner?	Hospital:			Othor	26. Place of Deatl		•	•	./-
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DIVISION	nding th.	tior	1 Natural 5 ☐ Pending 2 ☐ Accident investigati	(Month, Day	(Year) Ir	njury M	Work?	s 2 🗆 No			,	
<u>S</u>	Atte	ifica	3 Suicide 6 Could not 4 Homicide determine		ry - At home, far	m, street, facto	ory, office		28f. Location (nd Number or Run	al Route Number,
5	talor rs afte al Dir led in	Certification:	Torriode	Building, etc	. (Opecny)				City of To	wii, State	<i>5)</i>	
D	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune.	Medical	29a. Certifier 1 Certifying I 2 Medical Ex	Physician: To the best of aminer: On the basis of and manner sta	examination an	, death occurre d/or investigation	ed at the time on, in my opii	e, date and place, nion, death occur	and due to the red at the time	e cause(s , date and	s) and manner as d place, and due t	stated. to the cause(s)
	Veith Com	Σ	29b. Signature and title of certifier	. /			9c. License r				te signed (Month,	*
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			30. Name and address of person wh DA3BS, wm 31. Date filed (Month, Day, Year)	o completed cause of de	eath (Item 239)	Type, Print)	n.m	20 0	MUNOL) . V	m> 21	012
Ser.	Sta	te	31. Date filed (Month, Day, Year)	32. Registra	r's Signature			- 1		- 1 -		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** mb Jenuar 10: 20 PM 2010 /Medical Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City Examiner Datimore memoria If Under 1 Year | If Under 24 Hrs. | 8, Date of Birth | 1 Hours | Min. | Month, Day, 7. Age (In yrs. last birthday) Yrs. Social Security Number 9. Birthplace (State or Foreign Country) **Funeral** 36-2886 1 M 2 □ F Director (ardino Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits T is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Modical Experiment must be notified at Director 1XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No If Yes, Give Year or Dates: Specify. \$ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) unera Department of Health and Mental Hygis Important; If item 27 is marked other i any injury or other traumatic event, III 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Willi Ba 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 1 Surial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 3 Removal from State 22-2010 23a. Palvi. Enter the disease, or complications that caused the death. Do not enter the model of dying, such as cardiac or shock of heart failure. List only one cause on such line.

Immediate ause (Final Approximate Interval Between Onset and Death **Physician** MIGIONAS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner be executed burial-tran and resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year Month Day 5 Other (specify) P.O. the Tyes 2 No 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ğ 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has hirector, page 2 s autopsy perform Division of Vital 1 ☐ Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 Mo 2 R/Outpatient 3 DOA 1 🔲 Inpatient this Medical Certification: To 28a. Date of Injury (Month, Day, Year) After th funeral 27. Manner of Death 1 (Thatural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 3 ☐ Suicide investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 0058860 JAN 21, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3333 calvert MI

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🎧 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year 11 32 HM 2010 Medical 4a. Facility Name (if not institution, give street and it 4b. City. Town, or Location of Death Examiner 4c. County of Death HOP FOR Balk'more Johns Social Security Number If Under 1 Year If Under 24 Hrs. 8 Date of Birth 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign Funeral 1 🔀 M 2 🗆 F Months Days 1 (Month, Bay, Year) 41 West Virginia 68 Director 5096 33-64-Usual Residence of Decedent 10a. State 10c. City, Town or Location and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits Examiner must be notified at Funeral Director 28a-f 1 ☐ Yes 2 💆 No Baltimore Co Dundalk 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? 23a 6923 Broening 21222 Road USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 \(\subseteq \) No 11. Marital Status 14. Race - American Indian. Black, White, etc à 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates. Vietnam "natural", 3 Divorced Specify: White Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) N/A Drywall Mechanic Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Cornwall Hymes Maxine Sponagle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 Dolores Cook Broening Road Dundalk, MD 21222 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗌 Burial 2 🛛 Cremation 3 🗀 Removal from State Bayview Crematory 1-21-2010 4 Donation 5 Other (Specify) Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Kaczorowski Funeral Home, PA 1201 Dundalk Avenue Baltimore, MD 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ resulting in death) Medical Due to (or as a coni Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to for as a consequence of the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death 5 Other (specify) ed by the a detached f 1 Yes 2 G 9 Unknown Hospital or Attending Physician: The law requires that the 24 hours after death.
 Funeral Director: After this certificate has been signed by th P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. iis certificate has been signed director, page 2 should be det 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed?
Yes 2 No Be 25. Was case referred to medical examiner?

1 \(\sum \) Yes 2 \(\mathbb{X}\) No 26. Place of Death (Check only one) Other: မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Bural Route Number filled in by determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 ho

To the Fune

completed fi 2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Day. Year) 341 30. Name and address of person who completed cause of death (Item Baltimore Drew State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year HOWE January 1535 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner notton Arunder anne 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. Birthplace (State or Foreign Country) Funeral Months Days Min. 1 □ M 2 🗓 X F Hours Director 175-28-8804 Feb 17, 1930 Pennsylvania Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show and highly or other traumatic event, it Medical Evanting must be notified at one. 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo 1 ☐ Yes 🎾 No Crofton Anne Arundel Marvland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2131 Davidsonville Road 21114 **USA** Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 1∑|Yes 2□No 1952 If Yes, Give Year or Dates: 1954 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💆 No ò Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Social Worker American Red Cross 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Paul Howe Emily Mohr 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janis H. Moravec, Sister 4601 Fifth Avenue Pittsburgh, PA 15213 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 01/21/10 Baltimore, Maryland 21. Signature of Funeral Service Licensee Thomas Gregor ²² Name and Address of Facility
Cremation Society Of Maryland, Inc. homow 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to find mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Day to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 □Yes 2 🗷 No 3 🔲 Ectopic pregnancy Month Day Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 filled in by the funeral director, page 2 should be 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 2 No 1 ☐ Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 1 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending Investigation 1 Natural 2 Accident 1 ☐ Yes 2 🗆 No after death Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier completely (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) XI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) D

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

JAN 21

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	1	For State Registrar		State of N	/larylan		rtmen <i>tificat</i>			and M		gien Reg. N	-211111		1163	
	1	. Decedent's Name (First, Middl	e, Last))							Date of Dea Month		ay Year	3.	Time of Death	
/sician ledical	L	Richard Alan Ha	ayes	5							Janua				4:30 A. ^M	
miner	4	a. Facility Name (If not institution	n, give :	street and number	er)		4b. City,	Town, or	Location o	f Death		4	c. County of Dea	th		
		3321 Augusta Ro			A (/	/a -4 6:-461\	If Under		iches		9 Date of Bird	<u></u>	Carro		(State or Foreign	_
neral ector		Social Security Number	6. Sex	M 2□F /	Age (In yrs.	last birthday) 53 Yrs.	Months	Days	Hours	Min.	8. Date of Birl (Month, Da Feb. 2	y, Year	r) Co	ountry) Vlai		
HOF	-	217-62-9549 Isual Residence of Decedent				33					rep. z	, <u> </u>	JJO Mar	yrai	10	
η.	1	0a. State 10b. County			10c. Cit	y, Town or Lo	cation								nside City Limits	
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<u>a</u>	L	3321 Augusta Ro	$\overline{}$					21				of	America			-
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by F		1 ☐ Never Married > Mar 3 ☐ Widowed 4 ☐ Divorced		1 ∐Yes \$ { If Yes, Give Year or Date		1	□Yes	ZXNo	Specify:				Specify: W	hite	ž	
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2		<u>Jack James Haye</u>									lroy H					_
		19a. Informant's Name/Relations	ship (Ty	rpe. Print)				,					or Town, State,			
		Catherine M. Ha	ayes	s (Wife)	20h E						chester		laryland Location - City or			_
6	1	1 ☐ Burial 2 ☐ Cremation		Removal from Sta	te	Place of Dispo cemetery, cren			e)	Jan.	21,					
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any injury or other traumatic event, the Modical Examiner must be notified at once. To Be Completed by Funeral Director	(m Jam	Vai	ho.		Ec. 32	khar 96 Cl	dt Fi	inera. 1 Dr	l Cha ive,	apel, F Manche	·A.	er, Mary	land	21102	
		22a. Party. Enter the disease, or spock, or heart failure. List	r compl	ications that caus	sed the deat	h. Do not ent	er the mod	le of dyin	g, such as	cardiac o	r respiratory a	rrest,	_	App	roximate rval Between	
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by Physician/Me	2	F FEMALE: 23b. Was decedent pregnant	2	23c. If yes, outcom			Ectopic p	regnancy	,				23d. Date of de			
Sicie		in the past 12 months? 1 ☐Yes 2 ☐ No		4 Pregnar	t at time of o		Other (s						Month	Day	Year	
Phy	-	9 Unknown							- i- D+ I		220 Did	obass	o use contribute t	o the co	use of death?	-
þ		art II. Other significant conditi	ons co	ntributing to death	1 but not res	ulting in the ul	iderlying c	ause give	mmranti.		1 🗆				4 ☐ Unknown	
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led in by the funeral dir	2	1 ☐ Yes 2 ☐ No 27. Manner of Death		28a. Date of I		ER/Outpatier 28b. Time of		28c. Injury Work	7 🗀 140		8d. Describe		6 ☐ Other (Speciary occurred	ecity)		-
		1 Natural 5 □ Pendir 2 □ Accident investi	ng gation	(Month,	Day, Year)	Injury	М		? Yes 2∐I	No						
		3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide detern		28e. Place of building,	Injury - At he	ome, farm, str	et, factor	, office		2	28f. Location (Street	and Number or F	ural Ro	ute Number,	
Sert		4 Normicide		bullaing,	etc. (Specif	9)					City of 10	WII, Gla	ile/			
Medical (29a. Certifier / Certifyi (Check only 2 Medical	ng Phy Exami	sician: To the be ner: On the basi and manner	s of examina	owledge, deat ation and/or in	occurred vestigation	at the tir	ne, date ar pinion, dea	nd place, a oth occurre	and due to the ed at the time,	cause date a	(s) and manner a and place, and du	s stated e to the	i. cause(s)	
completely filled in by the tuneral afrector, page 2 should be detached for use as Medical Certification: To Be Completed by Physician/Med	1	29b. Signature and pale of certifie	r		stateu.		29	c. License	number			29d. [Date signed (Mon	th, Day,	Year)	1
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND ITEM#17perFH, G899, 1/21/2010, WS State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician 3: JANUARY 14,2010 0 /Medical 01 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Woods NURISM Altimore ocial Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours Min. 1□ M 2 F 213-72-565 Usual Residence of Decedent Director November 19,1932 filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Yes 2 No Completed by Funeral Director M.D mor 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1512 Ke Ane 4.5,4 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? Race - American Indian Black, White, etc. 11. Marital Status 1 ☐ Yes 20 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) NURSING Homes Thighada None WR5519 15515/ AnT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Woodrum Pages 1 and 2 should be 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 is any injury or other trau 2/237 INA Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) WoodlAWN 21. Signature of Funeral Service Licensee 22. Name and Address of Facility briend BOTTS FUNERAL HOL BATTO, MD. 2/2 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Due to (was a consequence of): /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine ned by the attending physician and detached for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 2 No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an was and autopsy performed?

Ves 2.2 No 1∐ Yes Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 42 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No To the Hospital or Attenwithin 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10 WI 81 ress of person who completed cause of death (Item 23a) (Type, Print) 30. Name and ad Bornie 2845 Glen 500ury 40 31061 Munesca MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death AM Physician/ HARLOTTE TANUARY 20/0 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death -TIMORE 10SPITAL 7. Age (In vrs. last birthday If Under 1 Year I If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗱 F Sept. 8, 1954 55 MD Director 220-66-6532 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Anne Arundel Glen Burnie MD 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 21061 Glen Square - Crain Highway Funeral United Sttaes 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. White þ 1 X Never Married 2 Married within 72 hours after 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry ould be filed within 72 m and Mental Hygiene. is marked other than "r (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) **Healthcare** Nursing Assistant traumatic event, Be Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Sumame)
Adele Czaczaka 17. Father's Name (First, Middle, Last) of Health and Mental He files of Health and Mental H ပ Eugene Haynes 19a. Informant's Name/Relationship (Type, Print)
Laura Young - Cousin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Laura Young -8049 Veterans Hwy., #19, Millersville, MD 21108 a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of P Important: If ite any injury or ot once. 1 NBurial 2 Cremation 3 Removal from State 1-22-2010 4 Donation 5 Other (Specify) Holy Cross Cemetery Brookyln Park, MD 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final SHOCK Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner NEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of). TRACT IMPECTION URINARY use as the burial-transit The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last and attending physiciar Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 N No
9 Unknown for Month Pregnant at time of death Day detached 9 Unknown the ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ STAGE RENAL DISEASE 1 Yes 2 No 3 Probably 4 Unknown Completed DIABETES MELLIYUS TYPE II 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform 2 No Yes 2 No Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No 2 1) Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending 1 Yes 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 NOVER State

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DHMH 17 Rev 7/2009

Registrar

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of Vital

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical M 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday 8. Date of Birth **Funeral** 1 □ M 2 🕅 F Months -24-990 Hours (Month, Day, Year Director Usual Residence of Decedent 28a-f show 10b. County 10a, State 10c. City. Town or Location injury or other traumatic event, the Medical Examiner must be notified at 10d Inside City Limits Director 1 Yes 2 No more 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Funeral 23a items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. ò 1 Never Married 2 Married ₽ Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify. permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", any injury or other traumatic avent the Mental or other tr If Yes Give Specify: 3 X Widowed 4 □ Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Şeconday (0-12) College (1-4 or 5+) ondon Town Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle Maiden Surname) မ ldaughter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Dongtion 5 ☐ Other (Specify) If Funeral Service Licensee 21. Signatu 22. Name and Address of Facility Part 1/ Enter the disease of complications that caused the death shock, or heart failure. List only one cause on each line. not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Immediate Cause (Final Physician disease or condition Medical resulting in death) Due o or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine burial-tran and Due to (or as a consequence of) resulting in death) Last Physician/Medical that the death certificate be the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 🗷 No Month Pregnant at time of death 9 Unknown P.O. I Part II. Other significant conditions ontributing to death but not resulting in the underlying cause given in Part I. ate has been signed page 2 should be de 23e. Did tobacco use contribute to the cause of death? þ Records, To the Hospital or Attending Physician: The law requires Completed 2 € No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an death? perform After this certificate within 24 hours after death.

To the Funeral Director: After this certifical completed filled in by the funeral director, I of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 TResidence 6 Other (Specify) 2 No 읻 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending work? Division 1 Tes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check urse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only o

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death More **Funeral** Number 8. Date of Birth 9. Birthplace (State or Foreign Months 1 🗆 M 2 🗷 Marylan Hours Min Director 28a-f show aţ 10a, State 10b. Count 10c. City, Town or Location death with the Maryland 10d. Inside City Limits Director Examiner must be notified 1 Yes 2 No more ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give 2 No filed within 72 hours after 1 Yes 2 No Specify: "natural" 3 Widowed 4 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) 2121 marked other than Elementary/Seconday (0-12) College (1-4 or 5+) the unent of Health and Mental Hyant: If item 27 is marking y or other Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Held Ba ME MO Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Page 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Important: I any injury o 4 Donation 5 Other (Specify) Baltimore . Signature of Funeral Service Licenses 22 Name and Address of Facility Home 222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Objection Physician/ disease or condition resulting in death) 9 nan Medical Due to (or as a consequence of): Examiner mm thy Securifically list our discus-Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury D e to (or as a conseq - ce of) been signed by the attending physician and should be detached for use as the burial-transit death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery Box (3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Year 1 Yes 2 9 Unknown that the P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Hospital or Attending Physician; The law requires Records, 1 ☐ Yes 2 DNo 3 ☐ Probably 4 ☐ Unknown the funeral director, page 2 should it 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate I performe 2 🗌 No ☐ Yes 25. Was case referred to medical examiner? Division of Vital B B 26. Place of Death (Check only one) 2 No မြ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 M Other (Specify) We 5 pt 4 After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 2 No ☐ Accident Investigation within 24 hours after deat To the Funeral Director, 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) 18 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TONSON 6701 31. Date filed (Month, Day, 32. Adistrar's Signatur State Registrar

DHMH 17 Rev 7/2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 11:11 AM 00 16 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City Town, or Location of Death Examiner BALTIMORE AGNES HOS PI TA If Under 1 Year If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Pay, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 □ F 216-28-452 Director such Carolina Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. anti-fi flem 27 is marked other than "natural", or items 23a or 28a-f show ant. If item 27 is marked other than "natural", or items 23a or 28a-f show ant. It was the trainal to worll find at uny or other trainalt event, In. Medical Experiment The page 10. 10b. County 10d. Inside City Limits 10a State 10c. City, Town or Location rai", or items 23a or 28a-f show Examiner must be notified at Funeral Director 1 Dres 2 □ No More Street and Number 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ To If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Completed by Specify: Specify. 3 ₩idowed 4 Divorced Blac 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ rank Henry -rances VIIIIams 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health a
Important: If item 27 is
any injury or other trau
once. 410 other Ward M.D20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 Removal from State 2010 4 ☐ Donation 5 ☐ Other (Specify) ansdowne, MD 21. Signature of Funeral Service Licensee 25 Balto, MD 23a. Part 1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shook, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed and Due to (or as a consequence of) attending physician Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Records, ģ PROSTA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed OPI 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy After this certificate 1 □Yes 2 NO Vital 2 N/0 1 ☐ Yes ours after death.

erai Director: After this certifica filled in by the funeral director, p Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Thpatient 2 ER/Outpatient 3 DOA Certification: To of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 201C 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LAMICHHAME, DIMAN, 900 S. C ATON AV. BALTIMORE

DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Johnson January 2010 9:08pM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death #115 Prince Georges 7901 Laurel Lakes Court. Laurel 5. Social Security Number 9. Birthplace (State or Foreign Country) District 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth Month, Day, 1 🗆 M 2 🗔 Months Days Hours Director 50 212-64-6189 า๊ั959 May of Columbia Usual Residence of Decedent ıral", or items 23a or 28a-f shov Examiner must be notified at with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Prince Georges Laurel 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 7901 Laurel Lakes Court, #115 20707 United States within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No þ 1 Never Married 2 Married Specify: Chinese Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☑ No Specify: "natural", Completed 3 Widowed 4 Divorced American the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home of Health and Mental Hygie If item 27 is marked other in other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Page 1 and 2 should be Justeen F. Hively John J. Lee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John J. Lee, Jr./ Brother 12729 Buckingham Drive Bowie, Maryland 20715 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If any injury or ō 1 Burial 2 🔀 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 2010 Baltimore, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility Cremation Society of Maryland, Alice Iser 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Diabetes wellite Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or iinjury Due to (or is a consequence of): that initiated events resulting in death) Last Physician/Medical death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Pregnant at time of death signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Affective 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No certificate 1 ☐ Yes 2 ☐ No Hospital or Attending Physician; 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA eral Director: After this filled in by the funeral dir 4 ☐ Nursing Home 5 🗷 Residence 6 ☐ Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No. hours after death. ☐ Accident☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 24 (Check within 2 To the F 29b. Signature and title of certifie Boelre R112087 CRUP 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Janet M. Beebe, CRNP 14999 Health Center Drive, #201 Bowie, Maryland 20716 32. Registrar's Signature Registrar

Amend 16a-18 per HF G899 1/26/10 TT amend 1tem 16b per HR g899 1-27-10 Vt. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No, 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day **Physician** Barbara S. Johnson 7:12 pm 1 2010 11 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Good Samaritan Hospital Baltimore 5. Social Security Number . Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Months Days 1 □ M 2×E3×F 74 Director 5-13-1935 217-34-3589 MD Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show or than "natural", or items 23a or 28a-f sho Director MD Baltimore 1XYes 2 □ No na 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21213 3217 Ravenwood Avenue SA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 □Yes 2X No Specify. 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Khoosial sh**ecurity Administration** 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ne any injury or other traumatic event, IDs Market once. Social Security Elementary/Secondary (0-12) College (1-4or 5+) 12th 2 years Clerk Medicare 18. Mother's Name (Eirst, Middle, Maiden Surname)
Evelyn Eudora Green
Barbara S. Green 17. Father's Name (First, Middle, Last) Be Arthur Patterson ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lavenia Alexander-daughter <u>3217 Ravenwood Avenue Balto, MD 21213</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1-25-2010 Randallstown, MD King Memorial PK 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March East F/H LMilla Mar 1101 E. North Avenue Balto, MD 21202 23a. Part 1. Enter the usease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): VRE bacteremia Examiner Recurren Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Directo for as a consequence of burial-transit and Due to (or as a consequence of): P.O. Box 68760 attending physician Physician/Medical the as IF FEMALE for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) ☐Yes 2☐No detached signed by the 9 Unknown 9 Hinknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ pe 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed peen 24b. Were autopsy findings available prior to completion ocause of death?

1 Yes 2 No 24a. Was an autopsy penormed? yes 2 \(\square\) No To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, page 1 Yes 25. Was case referred to medical examiner?
1 Yes 2 □ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 2 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of cer D0069314 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Prajapati Waltham Woods Rd, Parkulle MD 21234 8813 31. Date filed (Month, Day, Year) State JAN 21 Registrar

Patient Known as Mory Eur Johnson
Baltimore. Maryland 21215-0036 Division of Vital Records, P.O. Box 68760 $\stackrel{\textstyle \sim}{\sim}$

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and 2 s Health am 27 i		Sarah J. Archer/Sister 3020	Stoney Lake Dr	.Apt.1A	Richmon	d, Virginia
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. In moortant: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Dispose cemetery, crem	sition (Name of natory or other place) unt Cemetery 1/	Date 18/10 R.S.	Location - City or	Town, State , Maryland
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Atten er deal ector; by the	Certificate:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, stree		28f. Location (Street a	and Number or Rura	Il Route Number,
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To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completed filled in by the funeral director, page 2 should be detached for use as the	Medical	29a. Certifier (Check only one) 1	gation, in my opinion, death occurred at	the time, date and place	ce and due to the ca	usea(s) and manner stated
To the within to the company		29b. Signature and title of certifie	29c. License number		Date signed (Month,	
		MBBS . MBBS	RES 000	JUN		2010.
3		30. Name and Address of person who completed cause of death (Item 23a) (Type, Pr LUIS ROSAS - CALDERON MBBS SING	AL HOSPITAL OF	CBATIN	ORE	
State Registra	e r	31. Date filed (Month, Day, Year) JAN 2 1 2010 Lever S. gare	,			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Harrison Leroy Month James 2010 01 6 2:40p. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death <u>Gilchrist Hospice</u> Towson Baltimore Social Security Number Age (In yrs. last birthday If Under 1 Year If Under g. Birthplace (State or Foreign **Funeral** 8. Date of Birth 1 🛛 M 2 🗆 F Months Days Hours Min 06 30 Director 212-28-4104 77 DC Usual Residence of Decedent ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Yes 2 No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 30th Street 21218 1604 East U.S.A. 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

14 Yes 2 No
If Yes, Give Black, White, etc. ģ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: Completed Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72 th and Mental Hygiene. 27 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) 12th grade Printer Baltimore Sun Paper 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) **Effie Turner** Arthur L. James 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 sh it of Health ai : If item 27 is F. Priscilla James-Wife 1604 East 30th Street, Baltimore, Md 21218 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Page 1 permit. Page 1 a Department of H Important: If ite any injury or ot 1 X Burial 2 Cremation 3 Removal from State Garrison Forest Vet 1/27/2010 Owings Mills, Md Donation 5 D Other (Specify) Signatu Funeral Service License March F/H West 4300 Wabash Ave, Baltimore, Md 21215 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between mock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ uncrea disease or condition Medical resulting in death) e to (or as a consequence of Examiner Sequentially list conditions, Examine Due to (or as a consequence of if any, leading to immediate burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical that the death certificate be 68760 the as IF FEMALE: nse 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year Yes 2 No detached g 🗌 Unknown g 🗌 Unknown P.0. cate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 ムショク ロ Vital Records, Hospital or Attending Physician: The law requires 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy within 24 hours after death.

To the Funeral Director: After this certificate Division of Vital director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🗹 No Certificate: To 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Tes 2 🗌 No Investigation 6 Could not be Accident 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Hourson.

Registrar

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6-701

32. Registrar's Signature

18W501, NO 21204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Union:

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** Day Month Year U Johnson 1782 Ù /Medical UIC DM 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 1606 1 treet East Baltmore Monument 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 2 🔀 F Months Days Hours Min 61 Director 216 541449 9/26/1948 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examination ust by notified at Baltimore Director MD 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a any Injury or other traumatic event, the Wedical Exambre once. 1606 E.Monument St. Apt #2 21205 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Federal Police Officer Federal Gov 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Albert Johnson Patricia Johnson ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Son Jerome J. Oakley 1606 E. Monument St Balto MD Apt #2 21205 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ardent Crem Serv 1/19/2010 Hanover Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityPhillip A Weatherford Fs PA 2431 E Oliver St Balto MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) 2 IMPE dichetes Mellin /Medical Due to (or s a consequence of): Examiner kidhey MARIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed 4 years Division of Vital Records, P.O. Box 68760 ng physician and as the burial-tran Due to (or as a donsequence of): Physician/Medical attending p IF FEMALE: If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 - Ectopic pregnancy Month Year 5 ☐ Other (specify) certificate has been signed by the rector, page 2 should be detached ☐Yes 2 No 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? with mastection 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Nes 2 □ No 1 ☐ Yes or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital Na Yes 2 □ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No To the Hospital or Attend within 24 hours after death To the Funeral Director; the 1 6 Could not be 3 ☐ Suicide in by t Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2.010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Paters

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

thispita

Hopkins

32. Registrar's Signature

Johns

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMEND TIEM#5#16b, perFH, G899, 1/21/2010, ws
State of Maryland (Perpagners of Pealth, and Mental Hygiene 2) 1 - For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** 13 2010 2:30p Platt Benjamin Johnson Jan /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Goodsamartian Nursing Center Baltimore 5.719199 it.0600 710-09-0600 710-09-0600 Usual Residence of Decedent 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 X M 2 □ F 101 Director 04 - 28 - 1908SC 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show the Medical Examiner must be notified at 1 √Yes 2 No Director 28a-f Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō items 23a 21206 3707 Bayonne AVE USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ Who If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Never Married 2☐ Married Baltimore, Marvland 21215-0036 'naturai", or 1 □Yes ¥□No BLACK 2 Specify 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16 Nord of Brainess/Industry 15. Decedent's Education (Specify only highest grade completed) orfold=Southern al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Maintenance Department 12 Railroad 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be f nent of Health and Mental ant: If item 27 is marked o ဂ္ William Johnson Dora Wheeler 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Etta McCray-Braxton 3707 Bayonne AVe Baltimore MD 212106 other 20b. Place of Disposition (Name of cemetery, crematory or other place)

Ardent Crem Serv 20a. Method of Disposition Date 20c. Location - City or Town, State Department of Important: If its any Injury or o 1 ☑ Burial 2 ☑ Cremation 3 ☑ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/19/10 Burial Pk | MC
22. Name and Address of Facility Phillip A. Mc Dermott Ohio Scioto. 21. Signature of Funeral Service Licensee WeatherfordFs PA 2431 E. Oliver Street Baltimore MD 21213 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause or each line. Immediate Cause (Final disease or condition resulting in death) **Physician** babl /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for se's consequence offs Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Box 68760, nding p. IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Day 5 Other (specify) P.O. ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. Completed by 1 🗆 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an page 2 s autopsy performed? Yes 2 MNo 1 ☐ Yes Division of Vital director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 ₩6 Medical Certification; To Hursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 A Hatural 5 Pending Injury death. 1 ☐Yes 2 ☐ No investigation 2 Accident within 24 hours after deatl To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ò 4 Homicide filled in 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in my opinion, death accurately the cause of the cau the Hospital 29a, Certifie completely (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number Lock Raven Blud cause of death (Item 23a) (Type, Print) 30. Name and address of person who completed 5601 Ba Ken Crrance Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 21 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year Florence B. Kelly Medical lanuary 2010 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Towson Baltimore | If Under 24 Hrs. | 8. Date of Birth | Hours | Min. | (Month, Day, Year) | Nov 8, 1933 Social Security Number If Under 1 Year 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days **Director** 073-28-1147 76 Yrs New York Usual Residence of Decedent 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f shou ury or other traumatic event, the Medical Examiner must be notified at "natural", or items 23a or 28a-f sho adical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Baltimore Timonium 1 Yes 21 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 200 Belmont Forest Court #104 21093 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, med Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Completed 3 Divorced 4 Divorced Specify: white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) unk housewife own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Francis Dickson Bergen Margaret R. Galligah 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Kelly/spouse 200 Belmont Forest Court #104 Timonium, MD permit. Page 1 and 2 Department of Health Important; If item 27 any injury or other tr 21093 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 D Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 X Donation 5 Other (Specify) Signatur of Euneral Sorvice Licensee State Anatomy Board 655 W. Baltimore Street Baltimore. MD 21201 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. 23a. Part Approximate Interval Between Onset and Death Immediate Cause (Final disease or Andition resulting in d. 11) Ph sician/ obstructive Chronic Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to him of cause. Enter Underlying Due to (or as a consequence of): Exami ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Cause (Disease or iinjury the Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Pregnant at time of death Month 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Yes 2 No 1 🗌 Yes 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 X No Other: 1 Tes ပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 4 Nursing Home 5 Residence 6 NOther (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident injury 5 Pending 1 🗌 Yes 2 🗀 No Investigation 24 hours after deat Funeral Director; filled in by the 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Defitying Frightenian to the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2149194 January 12, 2010 CRNP 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Towson, MD 6201 M. (harles Marian Grat 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Month \$0755M Arthur Jacob Tanuari Koch, Jr. 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Stor albot 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Pennsylvania **Funeral** 8. Date of Birth 1 🛛 M 2 🗆 F Months Days Hours Min (Month, Day, Year) 10/08/1924 203-01-7663 **Director** 85 Yrs Usual Residence of Decedent show Director 10a. State 10b. County er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 1 🗌 Yes 2 🛛 No MD Talbot. St. Michaels 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7829 Church Neck Road 21663 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married 1 ☐ Yes 2 🛛 No Specify: Completed 3 Divorced 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 tal Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Mechanical Engineer Government Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injuy or other traumatic even once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Arthur Jacob Koch, Sr. Emilia 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia D. Koch / Wife 7829 Church Neck Rd, St. Michaels, MD timore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 ☐ Other (Specify) 1/20/2010 Hanover, Maryland Anatomy Gifts Registry 21. Signature of Juneral Serv Lice s e 22. Name and Address of Facility Anatomy Gifts Registry Bal 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical **Examiner** 42 Sequentially list conditions, it any leading to in neulationause. Enter Underlying Cause (Disease or linjury Examine and -tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Pregnant at time of death 5 Other (specify) Month Dav Year Yes 1 ☐ Yes 2 ☐ 9 ☐ Unknown been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 23e. Did tobacco use contribute to the cause of death? Cardiomyapath Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completio of cause of 24a. Was an has e 2 s er this certificate has eral director, page 2 autopsy performed? neath Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending Accident 1 Yes 2 No Investigation

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 within 24 hours after death

To the Funeral Director: Λ

completed filled in by the i

State Registrar

Medical

29b. Signature and title of certifier

Suicide

4 Homicide

only one)

29a. Certifier

6 Could not be

determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

10053110

28f. Location (Street and Number or Rural Route Number, City or Town, State)

MD 21601

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** RETTA /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Seasons Hospice of Northwest Hospital Baltinore andallstown 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex If Under 1 Year 7. Age (In yrs. last birthday) **Funeral** Min Months Days 48 1 □ M 2 💢 F 213.80.340 20/1961 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f shov any Injury or other traumatic event, the Medical Examinat rount be notified at Mills 1 ☐ Yes 2 No MD Baltimore Owings Completed by Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code filed within 72 hours after death with USA 4509 Lyons Kun Circle, Apt. 201 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DQ NOT use retired) Elementary/Secondary (0-12) secours Hospital Office Manager 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lawrence Holle ပ 19b. Mailing Address (Street and Number or Rural Route Number Lity or Town, State, Zip Code) 2117 19a. Informant's Name/Relationship Type. Print) 4509 Lyons Run Circle, Apt. 201 Owing Mills, MD Dawn G. Walker 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 1XBurial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, MD Garden of 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Vouchn C. Greene Funeral SIG m Dardallstown MD 21133 Road werry Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, each as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical attending p for use as t IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death
☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 menths? Year Month Day 5 ☐ Other (specify) n signed by the a P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 □ Yes 2 No 3 Probably 4 Unknown After this certificate has been s funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 No 1 ☐ Yes or Attending Physician: 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Hospital: Other: 4 Nursing Home 5 Residence 2 No 3 DOA 1 Yes 1 Inpatient 2 ER/Outpatient 6 Other (Spec Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 ☐ Accident death. 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the t 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number of person who completed cause of death (Item 23a) (Type, Print

BUR MD 283 30. Name and address 31. Date filed (Month, Day, Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND TIEM#5perFH, G900, 2/16/2010, WS State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 0 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** FRANK **JOSEPH** LOWINSKI JANUARY 4:23P M 16,2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1401 CHAPEL HILL DRIVE ROSEDALE BALTIMORE 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Numb 1959 6. Sex 8. Date of Birth (Month, Day, Year) 7 – 24 – 1938 9. Birthplace (State or Foreign **Funeral** 1**Ճ**M 2□ F Months Days Hours Min 218-54-0939 MARYLAND 71 Yrs. Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the "Modical Examine in ust be rectified at 10a, State 10b. County 10c, City, Town or Location 10d. Inside City Limits MD BALTIMORE ROSEDALE Director 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1401 CHAPEL HILL DRIVE 21237 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1X Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. þ WHITE Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOME CARE CHURCH 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be LOWINSKI, SR. FRANK SOPHIA F. (SZYMONSKI) ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOANNA WAJEK/COUSIN 2940 GOLDEN FLEECE DR PASADENA, MD 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 1/21/10 LORRAINE PARK CEMEIERY 4 ☐ Donation 5 ☐ Other (Specify) FNTOMENT BALTIMORE, 22. Name and Address of Facility CVACH / ROSEDALE FUNERAL HOME 1211 CHESACO AVE ROSEDALE, MD 21237 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final coveryartery dulas Under coxclerate Physician 3 months disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to for as a consequence off To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the aftending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) P.0. 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1-18-10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7602 (MALON 31. Date filed (Month, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2010 ear January 7:18 PM M Concetta C. Lascuola /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Anne Arundel Crofton Care & REhab Center Crofton If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Oct 2, 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last hirthday) Funeral Months Days Hours Min. 1 □ M 2 👿 F Maryland 214-12-1978 88 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, if a Medical Expriner must be notified a once. 1 ☐ Yes 2 ☑ No **Funeral Director** MD Anne Arundel Odenton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21113 USA 1212 Odenton Road #322 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white ρ 3 ☐ Widowed 4 🕅 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) housewife own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Jospeh Lascuola 2 Rose Elizabeth Cascio 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laura Drehoff/daughter 8021 Fair Breeze Drive Severn, MD 21144 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 21. Sign ture of Funeral Service 22. Name and Address of Facility ้รั State Anatomy Board Baltimore, MD 2120 23a. Partil. Enter the dispase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate ause (Final disease or condition) 655 W. Baltimore Street Approximate Interval Between Onset and Death **Physician** He to (or as a consequence of) disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) signed by the a d be detached for 1 ☐ Yes 2 ☐ No 9 I Linknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 ☐ Yes 2 MNo 3 ☐ Probably 4 ☐ Unknown been si should b Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ᡚNo certificate has be irector, page 2 sl 1 ☐Yes 2 No after death.

Director: After this certific in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft

To the Funeral Di

completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar Highways SW Glen Burnie MO 21061

ayse of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year John Dona₁d 12241 AM 2010 Medical Tay 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death N/A Hospita Har boy saltimore Social Security Number 6. Sex 1 Å M 2 ☐ F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) MD 8. Date of Birth Funeral Months Hours 1 Month Day 926 219-10-8956 Director 84 Yrs. Usual Residence of Decedent fshov mit. Page 1 and 2 should be filed within 72 hours after death with the Maryland aratment of Health and Medrial Hygiene. aratment of Health and Medrial Hygiene. ordant: If item 27 is marked of other than "natural", or items 23a or 28a-f show ordant: If item 27 is marked of other than "natural", or items to notified at injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD N/A Brooklyn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3627 4th Street 21225 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc 1 Never Married 2 K Married þ Maryland 21215-0036 Specify: white 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) plumber contracting Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Solomon Lefkowitz Jenette Donahue 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Lefkowitz-wife Brooklyn, MD 21225 3627 4th Street, Baltimore, Important: If iten any injury or 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1XXBurial 2 Cremation 3 Removal from State Cedar Hill Cemetery 1-21-2010 Glen Burnie MD 4 Donation 5 Other (Specify) 21. Signature of Foneral Service Licensee 22. Name and Address of Facility Ambrose Funeral Home of Lansdowne 2719 Hammonds Ferry Road Lansdowne MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Bilateral Physician/ phellmon 140 WREKE Medical resulting in death) Due to (or as a consequence of). Examiner Sequentially list conditions, if any leading to immediate Due to (or se a consequence of) cause. Enter Underlying Examin attending physician and for use as the burial-transit Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Day Year Pregnant at time of death ed by the Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a, Was an 1 🗆 Yes 2 🗗 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Other: ၉ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manne of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director: A
completed filled in by the f Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Number Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2010 ind address completed cause of death (Item 23a) (Type, Print) of person who St, Baltimore asi Hamao 001 Hanover

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January 18, 2010 Dorothy L. Layfield 5:45 рм Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Dacota Assisted Living <u>Aberdeen</u> Harford **Funeral** Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day,) 1 M 2 X F Days Hours Mary Land 218-01-2552 **Director** 95 Usual Residence of Decedent or 28a-f shov 10a. State ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Harford Aberdeen 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 468 Belair Avenue 21001 USA death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian "natural", or ģ 1 Never Married 2 Married Black, White, etc. ☐ Yes 2 🛣 No Yes, Give Maryland 21215-0036 within 72 hours after 1 Yes 2 No Specify: Completed 3 Divorced Specify: Year or Dates White permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Clerk Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Robert L. Lavfield Dora Giesebrecht 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Robert Humphreys, Sr. 429 Greentree Circle Abingdon, Maryland 21009 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) oudon Park Cemeterv 1/21/10 Baltimore, Maryland 21. Signature of Funeral Service In 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave. Baltimore, Maryland 21229 23a. Part 1. Enter the disease, of shock, or heart failure. List complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician/ inforction muocardial disease or condition resulting in death) mnediate Medical Due to (or as a consequence of) overlyeass Examiner oviersin Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examiner Due to o as a consuluence of I-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Dav Year the a 5 Other (specify) 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Demenha Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 certificate has autopsy 2 🗌 No 1 ☐ Yes 2 No 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) ASSISTED 1 🔲 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 1 Natural 2 Accid 28d. Describe how injury occurred 5 Pending injury work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be ☐ Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title ofcertifier 29c. License number 29d. Date signed (Month, Day, Year) 2000 48050 20/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Aberdien mo S. Parke St Prashant Shukle.

Registrar

DHMH 17 Rev 7/2009

State

Registrar's Signat

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month Physician Estelle Laney AN 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner TIMORE AGNES KOSPITAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, June 2, 9. Birthplace (State or Foreign Country) 1918 North Carolina 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday Funeral Months Days Hours 1 □ M 2√□ F 91 **Director** 237-40-4258 Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Director 1 ☐ Yes 2 ▼ No Glen Burnie Anne Arundel Maryland 10e. Street and Number 10g. Citizen of What Country? 10f. Zin Code USA 21061 921 Dorking Rd. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ∏Yes 2 1 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐Yes 2 ☐No Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker permit. Pages 1 and 2 should be filed to Department of Health and Mental Hygic Important: If Item 27 is marked other 1 any Injury or other traumatic event, In 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Spriggs Isabelle Richard Taylor 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 921 Dorking Rd., Glen Burnie, MD 21061 Wendell Laney, Jr. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Maryland Loudon Park Cemetery 1/15/10 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave., Baltimore, MD 21229 Approximate Interval Between Onset and Death 23a. Part 1. Empt. the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. mmediate Cause (Final disease or condition resulting in death) ostadium **Physician** /Medical Due to (or as a consequence of): Examiner SIY 19m Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examine Due to (or as a consequence of): attending physician a for use as the burial-Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 5 ☐ Other (specify) ed by the a 9 D Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an cate has t page 2 s autopsy Idemia certificate 2 No Vital 1 ☐ Yes 1 □Yes 2 □VA 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 □ Yes 2 No 1 npatient 2 ER/Outpatient 3 DOA Certification: To of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division Hospital or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 1 🖫 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

Registrar JAN 2 1 201

31. Date filed (Month, Day, Year)

32. Legistrar's Signature.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

12 2010

ltimare MD-21229

Amend 10e & 19b, Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year JAM **Physician** 2001 rom Salv /Medical or Location of Death 4c. County of Death ntitution, give 4b City, Town, **Examiner** Fin ove ear If Under 24 Hrs. 8. Date of Birth Min. 8. Month, Day, 9 Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days 1 M 2 □ F 76-53 217-76-537 Usual Residence of Decedent Yrs. Director filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Modical Exemples must be notified at 1 Yes 2 ☐ No Funeral Director timore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2120 12. Was Decedent Ever in U.S. Armed Forces? 1 DYes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ೨ 19b. Mailing Address (Street and Num Level Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) (wife Pages 1 and 2 s ment of Health ar nn 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Dațe 20c. Location - City or Town, State Department of Important: If it any injury or o I 🖈 Burial 2 🗆 Cremation 3 🗆 Removal from State 2010 2 5 ☐Other (Specify) 4 Donation 22. Name and Address of Facility 21. Signature of Funeral Service Lice Home, P.A. Joseph L. Russ 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Ave Balto Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Lesosilicatio /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to include cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Date to for as a consequence of the death certificate be executed use as the burial-tran physician and Due to (or as a consequence of): 68760 Physician/Medical signed by the attending Box IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year detached for Pregnant at time of death 5 Other (specify) ☐Yes 2☐No o 9 Unknown 9 I Inknown σ. law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by the funeral director, page 2 should be 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □No 24a. Was an has autopsy performed? Yes 2 2440 certificate 1 Tes Vital or Attending Physician; 25. Was case referred to medical examiner?

1 ✓ Yes 2 ☐ No Be (26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 □ DOA Certification: To 1 ☐ Inpatient After this ŏ 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 ☐ Accident after death 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation in my opinion, death accurred at the control of the cause (s) and manner as stated To the Hospital within 24 hours a 29a, Certifie Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Reg 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** January 2010 6:45 A M Edith Morris /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3515 Horton Avenue Baltimore 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Min. Months Days Hours 1 □ M 2 🔽 F Sept 6, 94 Minnesota Director 215-03-5356 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Exeminer must be notified at once. 1∏Yes 2□No Director MT Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21225 3515 Horton Avenue USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) unk 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No 2 If Yes, Give Specify. white 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry unk (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Hilma Kristina Asman Ivar Jacob Ohman ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21225 3515 Horton Avenue Baltimore, MD John Morris Jr/son 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4X Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Ronald Director Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) (ARDIOJA rEDLAR ARTERIOSCIONOTIC **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Medical Certification: To within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 29a, Certifier 1 🕒 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier JANUALY 8, 2010 RITCHIE HWY PASADERA MIS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

8021

Mn

32. Registrar's Signatur

Antoine M. McClary, Sr Months Only Great Johns Hopkins Hospital Funeral Director Social Security Number: 4	ntry) MD 10d. Inside City Limits 1 X Yes 2 No Y? an Indian, Black, a C k dustry
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Medical Examiner Antoine M. McClary, Sr January 13, 2010 As Facility Name (if not institution, give street and number) Johns Hopkins Hospital Johns Johns Hopkins Hospital Johns	place (State or otry) MD Od. Inside City Limits 1 X Yes 2 No y? an Indian, Black, a C k
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The state of Death (Check only one) 24a. Was an autopsy performed? 1	osy findings available
Performed? death? 1 ✓ Yes 2 No 1 ✓ Yes	2 \ \ No
The state of Death (Check only one) 25. Was case referred to medical examiner? Hospital: I legation 2 M EB/Outputient	
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O see 1 to 1 Natural 5 Pending Investigation 1 Natural 2 Accident 1 Natural 5 Pending Investigation 3 Suicide 6 X Could not be determined 1 Specify found at home 2 Sec. righty at work? 1 Natural 5 Pending Investigation 1 1 1 Natural 5 Pending Investigation 2 Pending Investigation 3 Suicide 6 X Could not be determined (Specify) found at home 2 Sec. righty at work? 28d. Describe now injury occurred unk 2	Route Number, City
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and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month,	
Patri (Dromica - Pollo O.C.M.E. January 14, 2010	
30. Name and address of person who completed cause of death (Item 23a) Patricia Associate Dellate M.D. Assistant Medical Examinary 111 Dany Street Beltimers M.D. 24201	
Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	
Registrar 1AN 9 1 2000 form	

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			For	State	of Maryl					/lental Hy	giene		21125
			1 - State Registrar			(Certificat	e of Dea	ath		Reg. No.	2010	01186
	Physici		1. Decedent's Name (First, Midd Sam	_{dle, Last)} Char	les		Мо	sca		2. Date of De Month Janua		5,201	3. Time of Death 0 21:46 P M
No.	/Medio Examir		4a. Facility Name (If not instituti	-	,			Town, or Loca	tion of Death			County of Dea	
-			Johns Hopkins					Ltimore					
	Funeral Director		5. Social Security Number 216–16–3930	6. Sex 1 X M 2 □ F	7. Age (In)	yrs. last birthe 85 Yr	Months		nder 24 Hrs. Durs Min.	8. Date of Bi (Month, D. March 1	rth ay, 1924	9. Bir Mar	thplace (State or Foreigr ountry) Yland
	pur »	1	Usual Residence of Decedent 10a. State 10b. Count	v	100	City, Town o	or Location						10d. Inside City Limits
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	r 28a-	irec	10e. Street and Number				10f. Zip	Code			10g. Citi:	zen of What Co	ountry?
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980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy hiuty or other traumatic event, the Medical Everning must be nuithed at once.	Š	11. Marital Status 1 □ Never Married 2X Ma 3 □ Widowed 4 □ Divorce	Armed Fourtied 1 X Yes	2 □ No ive	n U.S.	13. Was Dece If Yes, spe 1 ☐ Yes		ic Origin? (Sp exican, Puerto ecify:	ecify Yes or No Rican, etc.)		14. Race - Ame Black, White Specify: Whi	e, etc.
5-0	72 hc	etec		ent's Education est grade completed))	1 (0	ecedent's Usu Give kind of wo	rk done durina	most of work	ing	16b. Kir	nd of Business	/Industry
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Ĕ	t. Pages 1 rtment of h rtant: If ite		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Specify)	State	cemetery,	risposition (Nar crematory or o	ther place) Cery	Janu 20,	2010	Dun	dalk,Ma	ryland
Bal	permit. Departr Imports any inju		21. Signature of Funeral Service	a triceristee			Conne.	d Address of F LTy Fun Sollers	eral H Point	ome Of Road,	Dunda Dunda	alk,P.A alk,Md.	21222
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Vital Records, P.O. Box	eath certific attending p for use as	by Physician/Me	23b. Was decedent pregnant in the past 12 months?		itcome of pre birth 2□F anant at time	etal death	3 Ectopic p				2	23d. Date of de Month	livery Day Year
o i	at the de by the tached	ysic	1 □ Yes 2 □ No 9 □ Unknown	9 Unk		or death	5 ☐ Other (sp	pecify)					
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ou :	iding Phys th. : After this (funeral dir	ţi	1 Natural 5 ☐ Pendi	ing (Mor	of Injury 1th, Day, Year	r) ZOD. 1111		8c. Injury at Work? 1 □Yes	2 □ No	28d. Describe	now injury	occurred	
Division of	After r dea ector by the	iţica	3 ☐ Suicide 6 ☐ Could	not be 28e. Place	e of Injury - A	t home, farm	, street, factory						ural Route Number,
á,	tal or s afte al Dir ed in	Certification: To	4 Homicide	Dulid	ling, etc. <i>(Sp</i>	ec <i>ity)</i>				City or To	wn, State)		
	of the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending ρ completely filled in by the funeral director, page 2 should be detached for use as	Medical	29a. Certifier 1X Certify (Check only one) 2 Medica	ing Physician: To the I I Examiner: On the I and mar	e best of my basis of exam nner stated.	knowledge, on hination and/	death occurred or investigation	at the time, da , in my opinion	ate and place, n, death occur	and due to the red at the time	cause(s) date and	and manner a place, and due	s stated. e to the cause(s)
i	withi To th	Me	29b. Signature and title of certific	er	13		290	. License num	ber		29d. Date	e signed (Mont	th, Day, Year)
			in py cu	m	U		Y	LES-	001		Janu	ary 1.	1,2010
			30. Name and address of person Margaret Cava	who completed cau	se of death (Item 23a) (Ty	rpe, Print)	Euster.	n Avo	nue B	altir	nove, n	10 21224
	Sta	to	31. Date filed (Month, Day, Year) 432.1	Registrar's Signature	gnature	, , 0			-			
	Registr			110 Serve		-	del						
DHM	IH 17 Rev 1/2	001	ANII & T S	110 /0000	P	19							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registral Reg. No. 2 U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month MARTIN **Physician** 1139 AM LOUISE MAJUGAL 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOWARD HOUALD GENERAL LOZUMBIA COUNTY HOSPIAN If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months 1 □ M 2 □ F 98 214-24-6637 16, 1911 Acme, WV Aug. Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b County 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Evandom must be notified at 1 ☐Yes 2 No Director Howard Co. Ellicott City 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 2640 Thornbrook Road 21042 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Ext. 1 1 □ Never Married 2 □ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify: þ 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 9 yrs. Cafeteria Manager Anne Arundel Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William . Batton Mollie Cooper ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2640 Thornbrook Road Ellicott City, MD 21042 Mr. Donald Paul Martin / Son Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Mem. Park | 01/22/2010 | Glen Burnie, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signature of Funeral Service Licenses Services PA; 1 2nd Ave SW; Glen Burnie, MD 21061 M01121 23a. Part 1. Enter the disease, or completions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one dause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MYOCARDIAL **Physician** ACUTE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-trar Due to (or as a consequence of): attending physician for use as the burial Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖼 No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) P.0. the 9 Unknown 9 Unknown p signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an has page 2 autopsy performe certificate 1 ☐ Yes 2 ☑ No of Vital 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 № No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 🔀 DOA ٩ this After thi 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury ne Hospital or Attending Pin 24 hours after death.
he Funeral Director: After toletely filled in by the funeral 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 1 M Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical npletely (Check only one) the within 2

0

State Registrar

31. Date filed (Month, Day,

29b. Signature and title of certifier

MIHALICLE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

00050538

HOURS COURT

29d. Date signed (Month, Day, Year) OLOS, PI, YM, UAL

GENERAL HOSPINGE

		29c, per DVR g899 1/21/10 TT #5 per State of Maryland / De	Partment of Health and Mental H	
	_	riegistra	ertificate of Death	Reg. No. U U U I I O O
Physician /Medical		1. Decedent's Name (First, Middle, Last) Cameron Ma. Facility Name (If not institution, give street and number)	CMorris 2. Date of D Month 4b. City, Town, or Location of Death	Day Year US AL
) Examiner		The Johns Hopkins Hospital	Baltimore City	V
Funeral Director		5. Social Security Number 6. Sex 1X M 2 F 7. Age (In yrs. last birthde	y) If Under 1 Year If Under 24 Hrs. 8. Date of E	Sirth Day, Year) 22 09 9. Birthplace (State or Foreign Country) MD
p _u >	- 1-	Jsual Residence of Decedent 10c. City, Town or 10a. State 10b. County 10c. City, Town or	Location	10d. Inside City Limits
Aaryla f sho ed at	- 1			1 √ Yes 2 □ No
ith the Man or 28a-f st e notified a	2	MD NA Balti 10e. Street and Number	10f. Zip-Code	10g. Citizen of What Country?
h with		4410 Mountview Road	21229	U.S.A.
r items 23a		11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	 Was Decedent of Hispanic Origin? (Specify Yes or N If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 	lo- 14. Race - American Indian, Black, White, etc.
Instantial		1 Never Married 2 Married 1 Ses 2 No If Yes, Give Year or Dates:	1 ☐ Yes 2X No Specify:	Specify: BlaCh
hour tural" al Exa		15. Decedent's Education 16a. De	cedent's Usual Occupation	16b. Kind of Business/Industry
ed within 72 houygiene. Her than "naturale, the Medical E. Completed	2	(Specify only highest grade completed) (G	ve kind of work done during most of working a. DO NOT use retired)	
d with	5	N/A N/A	N/A	N/A
be filed tal Hyg d othe event, Be (ן אַ	17. Father's Name (First, Middle, Last) Unknown	18. Mother's Name (First, Midd	
Ment Ment arked atlc e	2		Eiesha McMo	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director			ailing Address (Street and Number or Rural Route Num Mountview Road, Bal	
Heal Heal tem 2	\vdash	20a. Method of Disposition 20b. Place of Di	sposition (Name of Date	20c. Location - City or Town, State
Pages ent of It: If i			rematory or other place) lemorial Park 1/22/10	Woodlawn, Md
permit. F Departm Importar any Injur once.		1. Signature of Funeral Service Licensee	132 Paner of Has West	
o a m b b	1	XXIV VILLOU C. T. VILLOU V.	300 Wabash Ave, Balt	
	- 1	23a. Part . Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac or respiratory	y arrest, Approximate Interval Between Onset and Death
Physician	- 1	and the standard to the standa	100460515	0.00.0.0.2
/Medical Examiner		resulting in death) Due to (or as a ponsequence of):	14 Atresia	
e little	5	Sequentially list conditions, b. Due to (or as a consequence of):	7 11 10314	
xecuted and al-transit Examiner		if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		
		that initiated events C		
ysician ysician ne buri		d		
law requires that the death certificate se been signed by the attending phys 2 should be detached for use as the npleted by Physician/Media	M	IF FEMALE:		
tendir or use	land	23b. Was decedent pregnant in the past 12 months?	3 Ectopic pregnancy	23d. Date of delivery Month Day Year
the at the at ched f	33	1 Yes 2 No 9 Unknown Unknown	5 Other (specify)	
that the de de de detached detached		Part II. Other significant conditions contributing to death but not resulting in the	ne underlying cause given in Part I. 23e. Di	d tobacco use contribute to the cause of death?
v requires that been signed should be dishould be dish	2	Double outlet Right vent	11cle 11	_Yes 2 No 3 Probably 4 Unknown
The law require ate has been sig page 2 should I			24a. Wa	
The lay			pe 1 X Yes	normed? death?
in: Tificate for, pa	D .	25. Was case referred to medical	26. Place of Death (Check only	
Physician: this certificated director, To Be		examiner? 1 Yes 2 No Hospital: M Inpatient 2 ER/Outpa	tient 3 DOA Other: 4 Nursing Home 5 Re	esidence 6 Other (Specify)
g Ph er this neral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending (Month, Day Year) Inju		e how injury occurred
tal or Attending P rs after death. al Director: After the led in by the funera Certification:		2 Accident investigation	M 1 Yes 2 No	Character of Number of Dural Posts Mumber
r Atte		4 ☐ Homicide 6 ☐ Could not be determined 4 ☐ Homicide 6 ☐ Could not be determined building, etc. (Specify)		(Street and Number or Rural Route Number, Town, State)
0		29a. Certifier 1 Certifying Physician: To the best of my knowledge, do	eath occurred at the time, date and place, and due to t	he cause(s) and manner as stated.
pital or ours afte eral Dir filled in			r investigation, in my opinion, death occurred at the tin	
Hospital o 24 hours aff Funeral Di letely filled ir dical Cer		(check only one) 2 ☐ Medical Examiner : On the basis of examination and/o and manner stated.		
To the Hospital or within 24 hours aft to the Funeral Discompletely filled in Medical Cer			29c. License number	29d. Date signed (Month, Day, Year)
		one) and manner stated.	29c. License number D43577	29d. Date signed (Month, Day, Year)) anuary 14, 2010
To the Hospital o within 24 hours af To the Funeral Di completely filled ir	Medical	29b. Signature and title of certifier Pulled My	D43577 pe, Print)	January 14,2010
To the Hospital o within 24 hours aff To the Funeral Di completely filed if	INCAICAI	29b. Signature and title of certifier Muller Myre h C	D43577 pe, Print)	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 January Elizabeth A. McCleery 9:50a Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrest Hospice Baltimore Co. Towson 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth g. Birthplace (State or Foreign **Funeral** 1 ☑ M 2 👿 F Months Days Hours Min. July 14 1928 Brookton, MA Director 186-22-8950 81 Usual Residence of Decedent 28a-f show 10a. State 10b. County at 10c. City, Town or Location Director 10d. Inside City Limits "natural", or items 23a or 28a-f sl edical Examiner must be notified 1 X Yes 2 □ No Erie PA Erie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 16506 2293 Mayflower Dr. TISA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 14, Race - American Indian. Armed Forces Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. by permit. Page 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hyglene. Important If item 27 is marked other than "natural", or any injuy or other traumatic event, the Medical Examirany in 1 Never Married 2 Married ☐ Yes 2 🔀 No 1 ☐ Yes 2 🔀 No Specify: white If Yes, Give 3 Widowed 4 X Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Promotions Manager Television 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Erskine Myers Minnie Tippet King 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12605 Ivy Mill Rd, Reisterstown, MD 21136 Carla M. Waskiewicz - daughter 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a, Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/17/2010 | Hampstead, MD Cremation Signature of Fundya Se 22. Name and Address of Facility 11824 Reisterstown Rd Eline Funeral Home Reisterstown, MD 21136 23a. Part 1. Enter recipiease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ 0 ean disease or condition resulting in death) Medical Due to (or as a consequence Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): i filled in by the funeral director, page 2 should be detached for use عد المستخدمة. Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a, Was an autopsy 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Hospital: Other: ျ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No iniury Natural 5 Pending death. Accident Investigation 24 hours after deatle Funeral Director: 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my college, death Medical

Registrar DHMH 17 Rev 7/2009

State

eted

within 2 To the I

29a. Certifier

(Check

only one)

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

6-701

3 Certifying Nurse Practioner: To the best of my knowledge, death occurre

MA

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HOVER

sh, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

517

32

50

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year JANUARY 10:49 <u>Helen Teresa Martin</u> 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner ST. AGNES HOSPITAL BALTIMORE n/a 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🛣 F Months Days Hours Min Director 217-26-2053 11/11/29 Maryland Usual Residence of Decedent 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, Inc. Micilial Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 XYes 2 □ No MD Baltimore 5 4 1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2004 Casadel Avenue 21230 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐Yes 2 ▼No Specify. þ Specify: 3 ₩ Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiens Important: If Item 27 is marked other tha any Injury or other traumatic event, Inc. 100c. 12 Nurse Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Helen Kimmel ပ George Narer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 725 Old Benefield Rd. Severna Park, Maryland 21146 <u> Timothy Martin / Son</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Cemetery 1/22/10 Baltimore, Maryland 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Lifer 22. Name and Address of Facility Loudon Fark Funeral Home 3620 Wilkens Ave. Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or conshock, or heart failure. List of plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician PULMONARY EMBOLISM DALS-WEEPS disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner DAYS - WEEK NEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner that the death certificate be executed burial-tran Due to (or as a consequence of): P.O. Box 68760 Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 □ Yes 2 ► No Month Day Year 5 Other (specify) 9 Unknown reate nas been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? /ital Records, Be Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 → No Hospital or Attending Physician: The law 24a. Was an autonsy 1 ☐ Yes funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Division 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No within 24 hours after deatl To the Funeral Director: filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier P21798 JANUARY 18, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 CATON AVE NUE BHAVANDEEP BATAT BALTIMORE, MARYLAND

Registrar

State

31. Date filed (Month, Day, Year)

Physici /Medi Examir

Funeral

For	Please	Type or Prin		ndelible Ink. partment of F		-	-	
State Registrar			C	ertificate of l	Death	Reg	1. No2 () (0119
1. Decedent's Nam	e (First, Middle, La	ast)				2. Date of Death Month	Day Year	3. Time of Death
CITA	RLES	Noanis				44 6	17 200	1 1 1/1/2
	If not institution, gi	ve street and number)	md Rehal		Location of Death		4c. County of De	ath
5. Social Security	lumber 6.	1	e (In yrs. last birthda 82 Yrs.	Months Days	if Under 24 Hrs. Hours Min.		(ear) 9. B	irthplace (State or Fore Country) MD
Usual Residence of 10a. State MD	10b. County	/A	10c. City, Town or	Location Baltimo	re City			10d. Inside City Limi
10e. Street and Nu 1153 H	_{mber} Haubert S	treet		10f. Zip Code	21230	100	g. Citizen of What C USA	Country?
11. Marital Status 1 ☐ Never Mari	ried 2 Married	12. Was Decedent Armed Forces? **Z*Yes 2 If If Yes, Give Year or Dates:	No	3. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 🏖 No	ispanic Origin? (Sp in, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	14. Race - An Black, Wh	nerican Indian, ite, etc. White
(Spec	15. Decedent's E cify only highest gr pndary (0-12)		(Gi	cedent's Usual Occup ive kind of work done of e. DO NOT use retired Director	during most of work	ing	Sb. Kind of Busines Maintenar	s/Industry nce/Kernans Hosp
17. Father's Name		norris			18. Mother's Nam	e (First, Middle, Ma Margare	t Hooper	
	ame/Relationship ine A. Jo	(Type. Print) nes / Daug		ailing Address (Street reenwood R	and Number or Rui Oad, Pike	ral Route Number, C esville M	City or Town, State D 21208	, Zip Code)
		Removal from State	20b. Place of Dis cemetery, c Garriso	sposition (Name of rematory or other place IN FOREST V	A Cem. 1,	Date /28/2010	Oc. Location - City of Owings Mi	or Town, State
21. Signature of F	uneral Service Lice	nseeVictor P	Doda C	haries and Address 501 E. For	Števens I t Avenue	Funeral H Baltimo	ome, Inc re MD 212	230
23a. Part 1. Enter the shock, or head immediate Cause disease or condition resulting in death)	art failure. List only (Final on	pplications that caused one cause on each line.	the death. Do not ene. Lum a consequence of):	enter the mode of dyir		or respiratory arres	st,	Approximate Interval Between Onset and Death
Sequentially list co	nditions,	b						
Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or that inItiated event: resulting in death)	injury	с	a consequence of):					
IF FEMALE: 23b. Was deceden in the past 12 1 Yes 2	months?	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal death	3 ☐ Ectopic pregnanc 5 ☐ Other <i>(specify)</i> _	y		23d. Date of o	lelivery Day Year
Part II. Other signi	ficant conditions	contributing to death b	ut not resulting in the	e underlying cause giv	en in Part I.			to the cause of death?
						24a. Was an autopsy performe	prior t	
25. Was case referexaminer?	red to medical				26. Place of Deal	h (Check only one)		
1 Yes 2	HNO	Hospital: 1 ☐ Inpatie	ent 2 ER/Outpat	tient 3 DOA Oth	er: 4 Nursing Ho	ome 5 🗌 Residen	ce 6 ☐ Other (S)	pecify)
27. Manner of Dea 1 ☑ Natural 2 ☐ Accident	5 ☐ Pending investigation		y, Year) 28b. Time Injur	y Worl	T	28d. Describe how		
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Injuding, etc	ury - At home, farm, c. (Specify)	street, factory, office		28f. Location (Stre City or Town,		Rural Route Number,
29a. Certifier (Check only one)	1 ☐ Certifying P 2 ☐ Medical Exa	hysician: To the best miner: On the basis o and manner sta	f examination and/or	eath occurred at the til r investigation, in my c	ne, date and place pinion, death occu	, and due to the cau rred at the time, dat	use(s) and manner e and place, and d	as stated. ue to the cause(s)
29b. Signature and	title of certifier	2		29c. Licens	36		Jun 17,	2.1.
	nunity 1	completed cause of d	leath (Item 23a) (Typ Re 4n 6	e, Print) . Con ka	39N Lock	Ravia :	Blud. Ba	2011 1 th:more 212
J. Date filed (MOI	N 9 1 201	1 Revers	A. bo	Med				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death James O. Nash, Jr. Physician/ 13:35 PM Lamory 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Union Memorial Hospital N/A Baltimore 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1XXM 2 □ F Months Hours 219-58-0835 Director 58 Nov 22, 1951 MD Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director MD N/A Baltimore XX Yes 2 No 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? Funeral 800 West 32nd Street 21211 items 23a U.S.A. hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces? Black, White, etc. ō ģ 1 Never Married 2 Married Yes Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2XXNo Specify: "natural", Specify: White 3 Widowed 4XXDivorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Johns Hopkins Hospital Medical Lab Technician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Menta Important: If item 27 is marked any injury or other traumatic and once. ٥ James O. Nash, Sr. Jane E. Bortle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Woolford (Sister) 212 Linganore Ct. Westminster, MD 21158 Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Xurial 2 Cremation 3 Removal from State cemetery, crematory or other place) Cedar Hill Cemetery 1/21/10 Glen Burnie, MD 4 Donation 5 Other (Specify) 21. Signat 22. Name and Address of Facility Burgee-Henss-Seit 3631 Falls Road Name and Address of Facility z Funeral Balto, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate nterval Between Onser and Dea and Death Heute Immediate Cause (Final Physician COMMUNICA disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** lo years COPD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) sician and burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director; After this certificate has been signed by the attending physician and 10 4 eous. LOTONARY disease Due to (or as a consequence of) resulting in death) Last physician s the burial Physician/Medical ίa Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) signed by the a Yes 2 No Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy page perform death? 2 🗌 No 1 🗌 Yes Yes within 24 hours after death.

To the Funeral Director: After this certific qompleted filled in by the funeral director, 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? 2 1 No Other: 1 MInpatient 2 ☐ ER/Outpatient 3 ☐ DOA ျ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 Yes 2 No 5 Pending injury Accident
Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) / occe 01/16/2010 AT 2438946 M. D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Horpita Union Memorial Macu 32. Registrar's Signature State 2 1 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Day Month Physician 2010 *porne* SM 08 /Medical 4a. Facility Name (I not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Rohab B altimore 010) UISING N/A If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 🕽 F Dec 12, 1931 Director Wash., DC 577-40-5756 78 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show Examiner must be notified at 1 XYes 2 No Director **Baltimore** N/A Maryland 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code or Items 23a or U.S.A. 21215 3426 Park Heights Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2☐ If Yes, Give Year or Dates: 2 No Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: þ Black 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) other traumatic event, the Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 12 should be filed within 1 th and Mental Hygiene. 7 Is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary Carter John Harrod ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If item 27 Is n any Injury or other traun 1023 Carrollton Avenue Baltimore, Maryland 21217 JoAnn Osborne 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐xBurial 2 ☐ Cremation 3 ☐ Removatifrom State Baltimore, Md. 01/19/10 4 Donation 5 ☐ Other (Specify) Baltimore National Cemetery 21. Signature of Funeral 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 23a. Part1. Friter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** aPthero Sclean disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transi Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Month Day 4□Pregnant at time of death 9□Unknown signed by the a 5 ☐ Other (specify) ITYES 2 No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed this certificate 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) မှ 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After To the Hospital or Attending within 24 hours after death. To the Funeral Director: After 1X Natural 5 ☐ Pending investigation 1 Tyes 2 □ No 2 ☐ Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide within 24 hours a To the Funeral I 1 Acertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Maccom 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

MAEEM

31. Date filed (Month, Day, Year)

32. Registrar's Signature

, SOI DOLPHIN STREET, BALTIMORE MD 21217

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Darlene Price 1-17-2010 q00:8 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 11142 Philadelphia Road White Marsh Baltimore Co. 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Date of Birth (Month, Day, 1 □ M 2 🖺 F Months Days Hours Min. 215-52-2650 49 27-1960 Marvland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No MD Baltimore Co. White Marsh 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11142 Philadelphia Road 21162 USA 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Armed Forces?
1 ☐ Yes 2 ☑ No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2X Married 1 ☐ Yes 2 ▼ No Specify. Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) City of Elementary/Secondary (0-12) College (1-4or 5+) N/A Baltimore Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frank Koluch Alice Lozoski 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $2\,1\,1\,6\,2$ Rick Price/Husband 11142 Philadelphia Road White Marsh, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State $1-21^{\text{Dat}}2010$ 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Sacred Heart of Jesus Cem. 4 ☐ Donation 5 ☐ Other (Specify) |Dundalk, MD 22. Name and Address of Facility Kaczorowski Funeral Home, PA Dundalk Avenue Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death of dving, such as cardiac or respiratory arrest. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Directo (or as a consequence of): and any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy 2 🔯 No 1 ☐ Yes 2 □ No 1 □Yes 26. Place of Death (Check only one) examiner? Other: 4 \(\sum \) Nursing Home 1 🔲 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident 1 🗆 Yes 2 🗆 No

Examiner sician and burial-trans physician s the burial P.O. Box 68760 attending p signed I I be det Division of Vital Records, page 2 should or Attending Physician: The law certificate director, After this funeral hours after death uneral Director: /

Be Completed Certification: To filled in by the

Physician

/Medical

Examiner

Funeral

Director

show

Director

Funeral

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Completed

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Examiner

Physician/Medical

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r is marked other than "natural", or items 23a or 28a-f shor traumatic event, tre Prodical Examinar must be notified at

death with the Maryland

within 72 hours after

12 should be filed within 7 h and Mental Hygiene. 7 Is marked other than "r

permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked or any Injury or other traumatic ev

Physician

/Medical

Baltimore, Maryland 21215-0036

23b. Was decedent pregnant Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 25. Was case referred to medical 27. Mann of Death Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

29d. Date signed (Month, Day, Year)

State Registrar

Medical

31. Date filed (Month

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

am Wood Road. wow

within 24 hours a To the Funeral D Hospital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1, Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** b^{M} 2010 2200 loro /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Square Med Himone eas edal (en 6. Sex 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, **Funeral** 1 □ M 2 🖾 F Months Days Hours Min 88 6-4-1921 220-01-2099 Director Maryland Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show the notified at 1 ☐ Yes 2 No Director MD Baltimore Co. Middle River 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 23a 9737 Matzon Road of Health and Mental Hygiene. If Item 27 is marked other than "natural", or Items 23s or other traumatic event, Ite Medical Exantral 21220 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2€ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race · American Indian, Black, White, etc. 11. Marital Status 1 ∏Yes 2X If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐Yes 2 X No Specify. Specify: White ò 3 ☐ Widowed 4 ₺ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 N/AHome Maker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be (unk) James Potter ျှ Caroline 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and:
Department of Health
Important: If Item 27
any injury or other tr.
once. Joanne Kraemer - Daughter <u>9737 Matzon Road Middle River, MD 21220</u> 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Stanislaus Cem. 1-20-10 Baltimore, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Kaczorowski Funeral Home, PA 21. Signature of Funeral Service License 1201 Dundalk Avenue Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Archy thmi disease or condition resulting in death) /Medical Due to (or as consequence of): Examiner disease propore 3-0 Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Year Month 5 Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 2 No 1 ☐ Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner?
1 Yes 2 □ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 🛛 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) To the within 2 To the F and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kahnamo DALTIMOR 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

JAN21

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2010 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death JANUARY 16, 2010 Physician/ ANTONINO **PISCIOTTA** 11:45PM Medical 4a. Facility Name (if not institution, give street and number)
GILCHRIST HOSPICE CARE CENTER 4b. City, Town, or Location of Death Examiner 4c. County of Death TOWSON BALTIMORE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) TTALY 7. Age (In yrs. last birthday) **Funeral** 6. Sex 8. Date of Birth Days (Month, Day, Year) 11-6-1925 1 KM 2 D F 219-40-8942 **Director** Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo MDBALTIMORE ROSEDALE 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1519 CUSTOMS ROAD 21237 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 1 Never Married 2 Married þ 1 Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: "natural", 3€ Widowed 4 □ Divorced Completed WHITE Year or Dates or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) should be and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) MACHINIST WESTERN ELECTRIC Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ۵ GIUSEPPE PISCIOTTA GIOVANNA (PISCIOTTA) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau LIVIA RHOADES/DAUGHTER 4206 GARLAND AVE NOTTINGHAM, MD 21236 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 1 - 21 - 10TIMONIUM, 4 ☐ Donation 5 ☑ Other (Specify) ENIOMEMENT DULANEY VALLEY MEMORIAL 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME Signature of Funeral Service Licensee T211 CHESACO AVE ROSEDALE, MD 21237 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical Examiner resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) and I-transit that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year signed by the a d be detached f 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I, 23e. Did tobacco use contribute to the cause of death? by 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed certificate Z No Yes 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) Hospital: 2 No Other: D inzoft 1 Yes 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completed filled in by the funera 27. Manger of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injuly occurred Natural 5 Pending injury work? 1 ☐ Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town. State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) Name and address of person who completed cause of death (Item (3a) (Type, Print) N. Chon 6701 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Box 68760

P.O.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** /Medical 4a. Facility Name (If not institution, give street and number) 4h. City, Town, or Location of Death 4c. County of Death Examiner Himore etuo. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 □ M 2 👺 F Yrs Director 249115 teua Jawara. Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

ant: If Item 27 Is marked other than "natural", or items 23a or 28a-f show ary or other traumatic event, the Medical Examinar in that be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28a-f shov the Madical Examinat must be notified at Baltimore Director 1 Yes 2 No Mary and 10f. Zip Code 10g. Citizen of What Country? Brunt St 34 2121 18 6 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 █No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify \$ acy 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) NONE MONE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Be Last) ್ತ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 to Department of Health an Important: If Item 27 Is any Injury or other trau 2001 Molton Way, Jeroud Baltimore Maryland 21244 +ONE! 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Carmel Signature of Funeral Server Baltimare, N 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as caldiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, signed by the attending physician is be detached for use as the board. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Part JL Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably funeral director, page 2 should Completed peens 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy perform 2 No 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of 1 After t 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 2 Accident investigation 1 ☐ Yes 2 □ No within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check onl onel 29b. Signature rtifie 29d. Date signed (Month, Day, Year) 30. Name and addr ause of death (Item 23a) 1510 31. Date filed (Month, Day, Year) egistrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year **Physician** PRICE 10:15 PM MARY TANUARY -201G VII /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Future Care Randallstown Baltimore Co. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Funeral Months Hours 1 □ M 2 🔽 F Days Director 213-20-5859 87 02 26 1922 Virginia Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 28a-f show must be notified 1 X Yes 2 No Director MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò death with 23a 3509 Powhatan Ave. Apt3 21216 Funeral U.S.A. items ? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. Pages 1 and 2 should be filed within 72 hours after cannot of Health and Mertal Hygiene.
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Into yor other than walked when the Medical Examiner 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: þ 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Urban Service Elementary/Secondary (0-12) College (1-4or 5+) 12th Grade Chauffeur Transportation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Williams မ Clemmie Bessie M. Johnson 19a. Informant's Name/Relationship (Transition) 194 Mailing Address (Street and Number or Rual Route Number, City or Town, State, Zip Code)

196 Apt. E Pikesville, MD 21208 Danita Phillips 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
any Injury or ot
once. 1 Burial 2 □ Cremation 3 □ Removal from State 01/23/10 4 Donation 5 Other (Specify) Druid Ridge Cem. Pikesville, MD 21. Signature of Funeral Service Licenses ²² Name and Address of Facility Own Jr. Funeral Home 2140 N. Fulton Ave., Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) としてる CANCER /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Useass or injury that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ nknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? has e 2 certificate ha 1□ Yes 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 ☑ No ို 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours af

To the Funeral D

completely filled in 1 👱 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) K.S.RAD. M.O 0 43462 JANUARY 18, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) K.S. ILAO. TV. O

State

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7310 32. Registrar's Signature 31. Date filed (Month, Day, Year)

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Physician /Medical Examiner

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Heatth and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show

Baltimore, Maryland 21215-0036

other traumatic event, the Medical Evandiner must be notified at

attending physician and for use as the burial-transit Division of Vital Records, P.O. Box 68760, signed by the a

To the Hospital o within 24 hours af To the Funeral Di State

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Im pedial: Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 9 Completed 25. Was case referred to medical examiner? Be 1 Yes 2 No Certification: To 27. Mann of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0057465 1/13/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001 J. Kajatakse, M.D

31. Date filed (Month, Day, Year)

32. Registrar's Signature

28355 mith Av. guite 263; Buthinar, MD. 21209.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician 10:15a Harry T. Parker Jan 17, 2010 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Baltimore Future Care--Winchester/Sandtown 9. Birthplace (State or Foreign 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 XM 2 F Director Maryland 219-28-0352 Oct 1, 1934 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ust be notified at 1 X Yes 2 □ No Director Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 2868 West Baltimore Street 'natural", or items 23a 21223 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) EXX disert Race - American Indian, 11. Marital Status Black, White, etc. 1 □Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes 2 □ No Specify: þ Specify: Black 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than, Elementary/Secondary (0-12) College (1-4or 5+) 1 and 2 should be filed withi Health and Mental Hygiene. **Never Worked** Disabled 12 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Nellie Waith Joseph Parker Pages 1 and 2 should ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health s Important: If item 27 is any injury or other tra 2868 West Baltimore Street Baltimore, Maryland 21223 Paulette Smith 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 01/20/09 Catonsville, Marvland Metro Crematory, Inc. 21. Signature of Funeral Service Censee 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line e death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** e disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner The law requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of): buria Box 68760. physician Physician/Medical the attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 🗆 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) ed by the a 1 □ Yes 2 □ No Ö 9 Unknown σ. signed beta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown should Completed has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performe certificate 2X No 1 □ Yes 1 Tes or Attending Physician: director 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 5 ☐ Residence 6 ☐ Other (Specify) this within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 1 Natural Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated and medical Examiner: On the basic of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the design of the course of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the design of the course of examination and/or investigation, in my opinion, death occurred at the time, date and place and place. 29a Certifier Medical sination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Hospital

Registrar

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

413

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2010 State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JÄNÜARY ANNA 2010 11:23A M POTASHNICK Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death NORTH OAKS HEALTH CENTER **PIKESVILLE** BALTIMORE 5. Social Security Number . Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F Hours Country) 12710/192 214-30-6982 Director 87 POLAND Usual Residence of Decedent fshow 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director or 28a-1 1 🗌 Yes 2 💢 No MD BALTIMORE PIKESVILLE 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 725 MT. WILSON LANE 21208 or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? 1 ☐ Yes 2 🕅 No 1 Never Married 2 Married Completed by 1 Yes If Yes, Give within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: WHITE "natural", 3 X Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me College (1-4 or 5+) Elementary/Seconday (0-12) LAB TECHNICIAN BIOCHEMISTRY Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ UNKNOWN UNKNOWN TOMBACHER UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MIRIAM COHEN / COUSIN ELDER LANE, PIKESVILLE, MD 21208 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State BETH JACOB CONG. 1/20/2010 FINKSBURG, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. . Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD, PIKESVILLE, MD. 21208 50 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequen of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the invertal director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death?

1 \(\subseteq \text{ Yes} \) 2 \(\subseteq \text{ No} \) 24a. Was an autopsy 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital Nursing Home 5 Residence 6 Other (Specify) 은 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural work? 5 Pending 2 🗌 No Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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Funeral		5. Social Security N			e (In yrs. la	ast birthday)	If Under 1 Ye	ear If Unde		B. Date of Bir	th(MM/DD/YYY	Y) 9. Birt Foreig	hplace (State or	
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5-0036 lied within 72 hours after death with the Maryland Hygiene. I other than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at once.	Completed	17. Father's Name (/Finet Baidalle I	5+		Busine	ss Owne		- Nama /Fi	ant Beliefella B	Compute		nsultant	
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ords, aw requir as been s	Completed									24a. Was a autop: perfor	sy		opsy findings availat empletion of cause o	
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on of Vital rending Physician: sath. or: After this certif	-	27. Manner of Death	h	28a. Date of Inju (Month, Day,Ye	ry ear)	28b. Time of Inj	· 1 —	ury at Work?	- 1	d. Describe h	low injury occur	red		
	catio	1 Natural 2 Accident	5 Pendir Investi	igation				Yes 2		1 6 (6			I Day to Marchael O	
Division At ours after dours after dours after diffiled in by	Certification:	3 Suicide 4 Homicide	6 Could determ		ury - At 110	me, rarm, street,	ractory, ornce	building, etc	. 201	or Town, St		er or Run	al Route Number, Ci	ıy
the Hos hin 24 h the Fur ppletely	Medical C	29a. Certifier 1		vsician: To the best of my liner: On the basis of exam	_									
To To con	Mec	29b. Signature and	title of certifier	and manner stated.			29c. Licen	se number		-	29d. Date sign	ed (Mon	th, Day, Year)	
		Caro	se A	allar			0.0	.M.E.			January 19	9, 2010		
5 V		30. Name and addre Carol Allan,	•	who completed cause of di istant Medical Exan		^{23a)} 111 Penn St	reet, Baltin	nore, MD	21201					
St Regist	ate	31. Date filed (Mont	h. Day Year)	32. Registrar	's Signatur	barles								_
regisi	18:11	20000 (4	- LVIV	Marie Land	W . J4									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 1/12/2010 **Physician** Madeline B. Robinson 11:55pm^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Keswick Nursing Home Baltimore . Age (In yrs. last birthday) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 ☐ M 2 🕱 F 153-14-4686 1/08/1920 Director UI Usual Residence of Decedent permit, Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐Yes 2 ☐ No MD n/a Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 409 Warren Avenue 21230 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XDSo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No white Specify: Specify: 3₺Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade comp 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Insurance Office Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Patrick Brennan Margaret Costello ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Paul Robinson, Jr. /Son 409 Warren Avenue, Baltimore MD 21230 20b. Place of Disposition (Name of cemetery, crematory or other place)
First Reformed Cemetery 1/16/10 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 X Bemoval from State Pequannock Township, NJ 4 Donation 5 Dother (Specify) 21. Strature of Funeral Service Licens Victor P. Doda, Jr. Charles L. Stevens Funeral Home, Inc. 1501 E. Fort Avenue, Baltimore MD 21230 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, or complications that caused to shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Onset and Death DEMENTIA **Physician** Lyd STAGE /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transi and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Completed by Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) teen signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to ... out not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? MEIL ITUS dia BETES 2 No 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy perform 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ s after death.
I Director: After this of in by the funeral d 27. Manner of Death 1 Natural 28a. Date of Injury Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

VG

State

and title of certifie

avui

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

29b. Signature

5901 North CHArles Street BAllimorp

D35102

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. lend #30 Per DVR G899 1/21/2010 JH
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** John Joseph Rowe 16_2010 4:00P January /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 13447 Overbrook Lane Prince Georges

9. Birthplace (State or Foreign Country) Bowie 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 1 ☑ M 2 □ F Months Days Hours Min. Director 89 254-20-5225 10/12/1920 New York Usual Residence of Decedent 10a. State 10d. Inside City Limits 10b. County 10c. City. Town or Location 28a-f show 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Mudical Examinar must be notified at 1 √ Yes 2 □ No MD Director Prince Georges Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 72 hours after death with 13447 Overbrook Lane 20715 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 □ No If Yes, Give Year or Dates; WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 □Yes 2 □ No ş Specify: Specify: White 3 Widowed 4 Divorced WWII Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r College (1-4or 5+) Elementary/Secondary (0-12) Electrical Engineer Simulation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John J. Rowe ပ္ Marie Homan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health em 27 i Helen Harrison Rowe/Wife 13447 Overbrook Lane, Bowie, MD Department of Healt Important: If item 2: any injury or other: Once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Pages 1 1 ☐ Buria! 2 X Cremation 3 ☐ Removal from State Ardent Cremation Services 01/20/2010 Hanover, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Ardent Cremation Services 7522 Connelley Drive, STe.N Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Schonu /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Exami and Due to (or as a consequence of): Box 68760. attending physician for use as the buria requires that the death certificate be Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) O. the pec 9 Unknown 9 🗌 Unknown signed by the ₫. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 2 \square No 1 ☐ Yes 2 - No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 | Yes 2 | 1√10 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 5 Pending investigation Injury the Hospital ...
thin 24 hours after death.

o the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier. 29d. Date signed (Month, Day, Year) 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Andrew Scott Dobin 4175 North Hanson Court Bowie, MD 20716 Registrar's S 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

JAN 21 2010

Physician /Medica **Examine**

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exerciting Instituted at once.

Physician /Medical

1 Decede	strar			Cei	rtificate of	Death		Reg. N	201	0 01200
1. Decede	ent's Name (First, Middle, L	ast)					2. Date of De		ay `	3. Time of Death
	cicia May						Januar	-		A /
4a. Facility	Name (If not institution, g	ive street and number)			4b. City, Town, c	r Location of De	ath		c. County of	
	Crest Villac Security Number 6.		Pacilit ge (In yrs. las)		Parkvi If Under 1 Year		rs 0 Dete of Bir		Balti	
	-26-2400	1 M 2 🔀 F	77	Yrs.	Months Days	Hours Mi)	9. Birthplace (State or Foreig Country) Maryland
	sidence of Decedent						3/1/1	.932		Maryland
10a. State	10b. County		10c. City, 7	Town or Lo	cation					10d. Inside City Limits
MD	Anne Ar	cundel	Seve	erna						1 □Yes 2 🔀 No
	t and Number	- 7			10f. Zip Code			10g. C		nat Country?
	Dividing Roa		E	10.1	21146		10 11 11		U.S	
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	idowed 4 Divorced	If Yes, Give Year or Dates:		1	1 □Yes 2 🛣 No	Specify:			Specify:	White
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	thy J. Reese od of Disposition	_/_Son			Dividing sition (Name of natory or other place		Date Pate			1.46 ity or Town, State
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	ture of Fulleral Service Lice	<u> </u>	71100	•	2. Name and Addre	2	. 1		-	•
	150/2	/		75	522 Conne	lley Dr	., Ste. I	Р, Н	anově	r, MD 21076
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		y one oddoo on odon ii	10.							
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within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physlcian: The law requires that the death certificate be executed

> 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8800 Walther Blvd, Parkville, MO 21234 Michealle G. CRNP MSN 2. registrar's Signature Hardison 31. Date filed (Month, Day, Year)

CAR, MSN

29b. Signature and title of certifier

29c. License number

R171944

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year 49pm 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Summitt Park Health & Rehab <u>Catonsville</u> 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🕱 F Months Days Hours Min. 06/1914 Country) 120-28-3850 Director Virginia Usual Residence of Decedent show 10a. State 10b. County 10d. Inside City Limits at 10c. City. Town or Location Director notified 28a-f 1

Yes 2 □ No MD Baltimore City Baltimore 10f. Zip Code 10e. Street and Numbe ò 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be with 1 Funeral 21207 4101 Springdale Avenue hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. Armed Forces?

1 Yes 2 K No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates Specify: Completed 3 X Widowed 4 Divorced Black the Medical 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry e 1 and 2 should be filed within 73 of Health and Mental Hygiene. If item 27 is marked other than or other traumatic event, the Me than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Bank Worker Banking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Indiana Carter Joseph Jackson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul L. Redd/Son Liberty Heights Avenue Baltimore, MD 21207 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 a
Department of F
Important: If ite
any injury or ott 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Ardent Cremation Services 01/19/2010 Hanover, Maryland 21. Signature of Funeral Service Licensee Ardent Cremation Services Drive, Ste. N, Hanover, MD 7522 Connelley 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Exami requires that the death certificate be executed burial-transit Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical P.O. Box 68760 the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? jo Month 5 Other (specify) Dav Year Pregnant at time of death signed by the a a Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Onknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an Hospital or Attending Physician: The law cate has page 2 s autopsy performed this certificate 2 🗆 No 1 Yes 25. Was case referred medical examiner? Division of Vital funeral director, 26. Place of Death (Check only one) Be Hospital Other: 1 🗌 Yes 2 🛮 No မ 1 Inpatient 2 ER/Outpatient 3 DOA rsing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred After injury Matural 5 Pending work? 24 hours after death. Funeral Director: A 2 No 2 Accident
3 Suicide Investigation within 24 hours after death

To the Funeral Director: / 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year)

State Registrar

DHMH 17 Rev 7/2009

wick

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Sig

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 17 Gladys Mary Robinson 2010 5 20PM Jan. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Genesis Randallstown Baltimore 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** MD Country) 1 🗆 M 2 🖵 F Months Hours Director 213-38<u>-7</u>959 Aug. Usual Residence of Deceden "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director 1 🗆 Yes 2 🔀 No MD Reisterstown Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12003 Tarragen Rd. Apt. J. 21136 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces Black, White, etc. 1 Never Married 2 Married þ Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: If Yes, Give Specify: Black 3 Widowed 4 Divorced Completed Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Wilbur Jackson Mary Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roberta R. Johnson/daughter 12003 Tarragon Rd., Apt. J, Reisterstown, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 22, 2010 5 1 Xurial 2 Cremation 3 Removal from State Dulaney Valley Memorial Gardens injury Timonium, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Bicenses

Michael J. Flagte 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley, Inc.
10 W. Padonia Rd., Timonium, MD 21093 any 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ohuni Pnysician/ Obsmetive disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause, Enter Underlying Cause (Disease or linjury Due to for as a consequence of Exami the attending physician and hed for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 Oo cate has been signed by the atter page 2 should be detached for Month Day Pregnant at time of death 5 Other (specify) g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Inknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate has Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director, After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital ျှ 1 Inpatient 2 ER/Outpatient 3 DCA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 5 Pending 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Mule D4768 20/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Raymond Mille Z835 Smith Ave, Ballmore, MD 21209 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 01209 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death , Day 20 Physician/ Elizabeth C. Smith Year 2 0 1 January 5:30AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c, County of Death 4916 LaSalle Road Hyattsville Prince George's 5. Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 X Months Days Hours Sept 1 Director 578-24-6042 92 191 Virginia Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Prince George' MD Hyattsville 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4916 LaSalle Road Funeral 20782 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 Married 72 hours after Yes 2 No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates "natural" Specify: Black 3 Widowed 4 Divorced Completed other traumatic event, the Medical 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) 12th College (1-4 or 5+) should be filed with and Mental Hygien ris marked other tl Homemaker Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Cooke Theresa Swann 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra 6090 Red Squirrel Place, Keith Smith (Son) Waldorf MD 20603 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State MD Veterans Cem. 1/27/2010 4 Donation 5 Other (Specify) Cheltenham, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Latimore Funeral Services Latemere 9013 Annapolis Road, Lanham MD 20706 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Many yrs Physician/ Dementia disease or condition Medical resulting in death) Examiner Due to (or as a consequence of) Alzheimers Disease Many yrs Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) and -transit Cause (Disease or iinjury death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) nding physician Physician/Medical Records, P.O. Box 68760 the as nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? 1 ☐ Yes 2 🔀 No jo Pregnant at time of death Month Day Year signed by the a or Attending Physician: The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Hypertension, Diabetes, Hypothyroidism 1 Yes 2 No 3 Probably 4 Unknown Completed should peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of certificate has tirector, page 2 s autopsy performed' death? 1 ☐ Yes 2 ☐ No 1 Yes 2000 Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 🔀 No Other: ျာ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 1X Natural 5 \square Pending n 24 hours after death. e Funeral Director: Aft bleted filled in by the fur 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Hospital Medical 1 😾 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 🛄 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 hoi To the Fune completed fi 3 📙 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of Certified 29d. Date signed (Month, Day, Year) January 21, D31001 2010

State Registrar Registrar's Signature

7500 Greenway Center Dr., Greenbelt, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Stuart J. Turkewitz, M.D.

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day housey JOSEPHINE C. SASSANI 20 , <u>20/0</u> County of Death 4a. Facility Name (If not institution, give street and number) 4c. 4b. City, Town, or Location of Death Canklin Square Social Security Number 1 6 500 Hospital Centel osedale If Under 1 Yea 8. Date of Birth (Month, Day, 0 3 / 1 6 / If Under Year) Months Days 1 □ M 2 🕮 F \mathbf{ITALY} 20 4244 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 □Yes 2X No. BALTIMORE ROSEDALE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1216 BERKWOOD ROAD 21237 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ∐Yes 21 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify Specify: WHITE 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 0 BOOKKEEPER KENWOOD KITCHENS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) **ANGELO** PUPO ROSINA **PUPO** 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROSLYN UDRIS/DAUGHTER 214 LINHIGH AVE BALTIMORE, MD 21236 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 01/23/10 4 □ Donation 5 □ ther (Specify) FNIONBMENT BALTIMORE, MD GARGENS OF FAITH 22. Name and Address of Facility CVACH / ROSEDALE FUNERAL HOME 21. Signature of Funeral Service Licensee 21237 1211 CHESACO AVE BALTIMORE, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sladder Car Due to (or as a consequence of): ance Sequentially list conditions, if any, leading to immediate cure. Else carping Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 □Yes 2 □No 9 Hlnknown 23e. Did tobacco use contribute to the cause of death? 2 No 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a Was an □Yes 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 inpatient 2 ER/Outpatient 3 DOA

Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trai attending physician nse for þ signed been has

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or items 23a or 28a-f show the Medical Exemples must be notified at

Director

Funeral

Be Completed by

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Examiner

MD

with the Maryland

death

Pages 1 and 2 should be filed within 72 hours after

of Health and Mental Hyginitem 27 is marked other other traumatic event.

permit. Pages 1 and 2
Department of Health a
Important: If item 27 is
any injury or other trau

Physician

/Medical

Baltimore, Maryland 21215-0036

this certificate After

Division of Vital Records, P.O. Box 68760, after death Director: filled in by the 24 hours a within 2 To the I ဂ္ဂ

Physician/Medical 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Completed 25. Was case referred to medical examiner? Be 1 Yes Certification: To 27. Manner of Death 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐Yes 2 ☐ No 2 🗀 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 \(\text{Homicide} \) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier (Check only and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

D36663

01/20/2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

alle M.D.

9000 Franklin Square Drive Baltimore MD; 21237 Willes Dr. Stuart

State Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
Amend #8, 10c, 15, & 19a, per Fh g901 3/2/10 TT
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year Physician M larietta Januar 201 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Ac. County of Death Examiner Baltimore seda T. Age (In rs. last birthday) voure ank Year I If Under 8. Date of Birth (Month, Day, Year) 1922 Birthplace (State or Foreign Country) Social Security Number Sex **Funeral** Min 219-12-9423 1 □ M 2 🗹 F Months Days Hours une 17, 2010 Bouth Carolino Director Usual Residence of Decedent the Maryland 10b. County 10c. City. Town or Location 10d. Inside City Limits 10a. State 28a-f shov o lant: If item 27 is marked other than "natural", or items 23a or 28a-f sho **Parkville** 1 ☐ Yes 2 🙀 No Funeral Director Maryland Baltimore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? death with 21234 inochemood true 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 2 should be filed within 72 hours after of and Mertal Hygiene. 1 Never Married 2 Married Maryland 21215-0036 1 ☐Yes 2 No Specify. \$ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 2+ Flood ministrative Accordant -CHKHOMH 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should re Department of Health and Merta Impo ant: If item 27 is marked any I jury or other traumatic wore JOUD I UIA 109855 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Daughter Thornewood Dr. Parkville, MD 21234 92000 Andrea 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State Date 20c. Location - City or Town, State enoral Park 1/25/2010 Baltimore, Maryland
22. Name and Address of Facility The Darrick C. Jares E. H. Memorial 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 1011 Park Heights Avo. Baltimore, MD 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Multiongar **Physician** /Medical Due to (or as a conse wence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed the burial-tran attending physician and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 **Z**No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 🗖 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cal 29a. Certifier (Check only one) 29b. Signature and tille of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person, who completed cause of death (Item 23a) (Type, Print) ya 9000 Frank Pierre RUS Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

John Thomas Swatski State of Maryland / Department of Health and Mental Hygiene 2010 01212 1- For State Certificate of Death Registrar Physician/ 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death **Medical Examiner** January 8, 2010 0908 hrs John Thomas Swatski 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 310 Capitol Court **Baltimore County** 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign **Funeral** If Under 1 Year Country Director Months Davs Hours 215-64-8476 50 1X M Feb 14, 2 F 1959 Maryland Usual Residence of Decedent 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show Examiner must be notified at once. 1 Yes 2 No MD Baltimore Baltimore, MD 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho
injury or other traumatic event, the Medical Examiner must be notified at once. Essex Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 310 Capitol Court 21221 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black, 1 X Never Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 2 2 X No Yes 3 Widowed 4 Divorced f Yes, Give Year 1 Yes 2 X No specify: Specify: white 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) event, the Medical laborer steel industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Henry Swatski Dorothy Ostroski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Swatski /mother 310 Capitol Court Essex, MD 21221 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 1 Burial 2 Cremation 3 Removal from State Donation & X Other Specify: Funeral Service L Ronald S 21. Signature of Funeral 86 22. Name and Address of Facility Anatomy Board more, MD 21201 655 W. Baltimore Street Physician used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Methadone intoxication Between Onset and /Medical a. Hypertensive Atheroselerotic Cardiovascular Disease Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last The law requires that the death certificate be executed signed by the attending physician and be detached for use as the burial - trans /sician/Medical AMENDED 23a, 27, 28a-f, permE, g899 1/22/10 TT UNPENDED Box 68760, IF FEMALE 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Ectopic pregnancy Fetal death Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify, 1 Yes 2 No 9 Unknown 9 Unknown o Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Δ, 1 Yes 2 No 3 Probably 4 ✔ Unknown Completed Records. 24a. Was an 24b. Were autopsy findings available prior to completion of cause of certificate has performed death? Yes 2 V No Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) of Vital Be Other Nursing Home 5 Residence 6 🗸 Other: Scene this Inpatient ER/Outpatient 3 DOA 1 🗸 Yes 2 No 28b. Time of Injury After 27. Manner of Death 28a. Date of Injury (Month, Day, Year 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Yes 2 X No 24 hours after death. Director; Pending 0900 hrs 1/8/10 FD Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 10 CApitol Court Essex, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc 6 X Could not be Suicide residence (Specify) Homicide 29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. January 9, 2010 30. Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month Registrar's Signature State

DHMH 17 Rev 1/2001 OCME 2006

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician 5:55 PM M 3, 2010 January Carl R. Spears /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner North Arundel Nursing & Rehab Ctr Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days 1**X** M 2□ F Hours 73 Director Sept 23. 093-28-4029 1936 North Carolina Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be nutified at 1 ☐ Yes 2 No Director MD Anne Arundel Glen Burnie 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 2 and 1 injury or other traumatic event, the Medical Examiner must be mone. 313 Hospital Drive 21061 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 If Yes, Give 1 Never Married 2 Married 2 No black Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☐ No ۵ Specify 3 Widowed 4 Divorced Year or Dates: Completed unk 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) janitorial unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Carl R. Spears ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) North Arundel Nursing & Rehab Ctr 313 Hospital Drive Glen Burnie, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5▼Other (Specify) in state 21. Sign lure I Funeral Service Licensee 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street enn Part LEnter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part Immediate Cause (Final **Physician** disease or condition resulting in death) ranoma 🧎 /Medical to (of as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter third-rightly Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) To the Hospital or AttendIng Physician: The law requires that the death certificate be executed Exami sician and burial-trans Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No been signed by the should be detached 9 D Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has be irector, page 2 sl 1 ∐Yes 2 SeNo 1 ☐ Yes 2 No 25. Was case referred to medical examiner? funeral director 26. Place of Death (Check only one) Other: 4 Mursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 1 Natural ours after death. neral Director: Af filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined

State Registrar

DHMH 17 Rev 1/2001

Medical

24 hours

within 24 hou To the Fune completely fi

29a. Certifier

(Check only

29b. Signature and itle

31. Date filed (Month, Day, Year,

a certifie

MAS

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

105 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Plan Narne MD 21061

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month WAR **Physician** 2010 Sco /Medical 4b. City, Town, or Location of Death
NTER BALTIMORE 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner LIVING + REHABILITATION CENTER CUMMUNITY If Under 24 Hrs. If Under 1 Year Social Security Number 225-56-9039 8. Date of Birth (Month, Day, Year) 9-4-1944 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1**X** M 2□ F Months Days Hours Min 65 VA Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 28a-f show th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the "Action Exect has not be notified at 1 XYes 2 No Director Baltimore MD na 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. USA 21206 6003 Point Pleasant Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Black Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify 3 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Disabled Veteran 12th grade 4 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Maggie Herbert ဂ္ Floyd Sutphin 19a. Informant's Name/Relationship (Type. Print) Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health a Balto, MD 21206 Linda A. Brown-Sutphin-6003 Point Pleasant Road item 27 other t 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages
Department of
Important: If it
any injury or o 1 □ Burial 2 □ Cremation 3 □ Removal from State Arlington Nat.Cem 1-29-2010 Arlington, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March East F/H Drank Mylan 21202 1101 E. North Avenue Balto, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final METASTATIC Physician LUNG disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) spital or Attending Physician: The law requires that the death certificate be executed ours after death.

In the control of the continue of the attending physician and the all birectors. After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the bursal-transit Division of Vital Records, P.O. Box 68760, 🧭 Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an After this certificate has funeral director, page 2 s autopsy 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral Completely filled Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 12+1 person who completed cause of death (Item 23a) (Type, Print) BULLEVARD, BALTIMORE, MD 21218 CAVEN

Registrar
DHMH 17 Rev 1/2001

State

Hospital or Attending Physician; The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, 24 hours a completely within 2 To the

s after de. ral Director: An filled in I

À State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

29a. Certifier

(Check only

Medical

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Discretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Amir Mirza-Alikhani, Ft Washington Medical Center, 11711 Livingston Rd, Ft Wash MD

29c. License number

2010

20744

Please Type of Print in Black Indelible ink. /Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Month Day 1:25 A.M Joseph Henry Shrader 2010 /Medical January 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll Hospital Center Westminster Carroll 5. Social Security Number If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months XXM 2□ F Director 232-32-5893 81 1928 West Virginia Usual Residence of Decedent the Maryland 10b. County 10a. State 10c. City, Town or Location ral", or items 23a or 28a-f show 10d. Inside City Limits Directo 1 ☐ Yes 2 No Maryland Carroll Hampstead 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or a important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, its moutes Is you it at a way be note. Funeral 21074 <u>4222 R Upper Beckleysville Road</u> America 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1) OXYes 2 □ No If Yes, Give Year or Dates: altimore, Maryland 21215-0036 1 ☐ Never Married 2 ☐ Married Completed by 1 ☐ Yes 2\ No Specify. Specify: White XIX Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)
Gunner's Mate 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Senior Chief United States Navy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ျ Stanley Gordon Shrader <u>Marie Lena Spade</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u> Wade Shrader (Son)</u> 303 Bishop Court, Westminster, Maryland 21157 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Jan. 21, 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 2010 Catonsville, Maryland Signature of Fundio Sérvice Line .22. Name and Address of Facility Eckhardt Funeral Chapel, P.A. 3296 Charmil Drive, Manchester, Maryland 21102 and 1. Enter the disease, or completations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Year /Medical Due to (or as a consequence of): Examiner +5 C V CLYS Sequentially list conditions, if any, leading to immediate cause. Clusease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): burial-transi and Due to (or as a consequence of): Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) P.O. 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 cate has been si page 2 should t 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 Hes 2 No Division of Vital 2 No 1 Hyes Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗂 No 1 Inpatient Certification: To this 2 ER/Outpatient 3 DOA funeral 27. Man of Death After t 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred ospital or Attending hours after death. 1 Natural 5 Pending investigation (Month, Day, Year) within 24 hours after deam.

To the Funeral Director: Af 2 Accident 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D64436 IANUARY 19 124 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SERUSO MD 32. Registrar Signature 200 MEMORIAL AVENUE, WESTMINSTER, MO 21157 ENRICO HINTHONY WGERUSO 31. Date filed (Month, Day, Year State JAN 21 2010

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month Day **Physician** Year :00 AM 05 Lula M.Schwinn 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner tal osedale saltimore Franklin 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, **Funeral** Year) 1 □ M 2 □ XF 98 Months Days Hours Min Director 219-16-9189 June 22,1911 Maryland Usual Residence of Decedent works ! 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits is marked other than "natural", or items 23a or 28a-f shot aumatic event, the Medical Examinar must be redified at Director Md. Balto. 1 ☐ Yes 2 ☐ No Nottingham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9606 Brookbend Road 21236 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🙀 No Specify. Specify White 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 10th17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any Injury or other traumatic event 18. Mother's Name (First, Middle, Maiden Surname) Be ပ James Pearman Martha Fredericks 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George Schwinn 9606 Brookbend Road Son Nottingham, Md. 21236 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5ДOther (Specify) Entombment Moreland Memorial 1-19-2010 Parkville, Md. 21. Sign the of Funeral Service Licensee 22. Name and Address of Facility Schimunek FunerAL Home 0 9705 Belair Rd. Nottingham, Md. 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** mesente /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed and physician an s the burial-tr Due to (or as a consequence of): Physician/Medical signed by the attending p as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? Yes 2 No certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated

Hospital or Attending Physician: To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

Baltimore, Maryland 21215-0036

Box 68760,

P.O. I

Division of Vital Records,

State

DHMH 17 Rev 1/2001

Registrar

29b. Signature and title of certifier

MonicaMarw 31. Date filed (Month, Day, Year)

32. Registrar's Signature

M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Marwahazi

9000

29c. License number

500000

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Glenn E. Smith, Sr. Month 2010 Medical January 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Towson Balto. Date of Bin... (Month, Day, Year, Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 🛣 M 2 🗆 F Months Days Hours Min Director 212-34-4723 ugust Marvland Usual Residence of Decedent 28a-f show 10a. State 10b. County with the Maryland Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director Md. Balto. Essex 1 🗌 Yes 2 ី No 10e, Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 8620 Kelso Drive Apt.B207 death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. ō þ 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No within 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: "natural", White Specify: Completed 3 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 75 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Meonee. Elementary/Seconday (0-12) College (1-4 or 5+) Salesman Liquor Sales Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Alfred Smith Edna Hutchins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DTR. Jill Pulliam 3310 Texas Avenue Parkville, Md. 21234 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 Donation 5 Other (Specify) 1-19-2010 Parkville, Md. Parkwood 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Schimunek Funeral Home 9705 Belair Rd. Nottingham, Md. 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or a a consequence of): Examiner Sequentially list conditions. Examiner if any, leading to immediate ocuce. Enter Ordenying Cause (Disease or linjury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed page 2 should be detached for use as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) Day Year g Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has performed? 2 🗆 No 2 X No 1 Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? 2 X No Hospital: Other: 2 1 🗌 Yes 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 ☐ Nursing Home 5 ☐ Residence 6 Ø Other (Specify 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Director: After 1 Natural 2/ Accident (Month, Day, Year) injury 5 Pending death. 1 🗆 Yes 2 🗆 No Investigation the 1 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined 24 hours Funeral Medical 29a. Certifier 1 🖰 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, gearly occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29b. Signature 6810 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

narles

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician Mary Katherine Schneider 18 2010 11:15 A^M Jan. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 9413 Dawn Dr. 21236 Balto. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1□ M 2□F Months Days Hours Min 62 **Director** April 18 1947 MD 213-52-5219 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits show ir than "natural", or items 23a or 28a-f show the Medical Evantiner must be notified at Director 1 ☐ Yes 2 ☐ No MD Baltimore Perry Hall 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9413 Dawn Dr. 21236 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white ğ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) within 72 (Give kind of work done during most of working life. DO NOT use retired) nd 2 should be filed within 7 alth and Menta! Hygiene.
27 is marked other than "ner traumatic event, the Med. College (1-4or 5+) Elementary/Secondary (0-12) 12 Customer Service Telecommunications n/a 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Heatth and Menta Important: If Item 27 is marked any Injury or other traumatic ev James Harold Ensor Elizabeth Concannon ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Ensor/sister 313 Radstock Rd., Catonsville, MD 21228 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Buria! 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 1/25/10 Glen Burnie, MD 22. Name and Address of Facility 21. Signature of Funeral 3 Lemmon Funeral Home of Dulaney Valley, Inc. 10 W. Padonia Rd., Timonium, MD 21093 Michael J. Slagte 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line tension Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Duel to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) P.0. signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Did tobacco use contribute to the cause of death? Division of Vital Records, ð 1 Yes 2 No 3 Probably 4 Unknown been si should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has page certificate 1 □Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred spital or Attending P nours after death. neral Director: After t 1**⊈** Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only and manner stated. 29c. License number 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) January 20, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Timothy G. Doyle, MD 7602 Belair Rd., Baltimore, MD 32 Registrar's Signature 31. Date filed (Maj 21 2010 A. parel Registrar

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Physician/ Medical		Immediate Cause (i disease or conditio resulting in death)			coleque		Wie								-	Uns	and Death		
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Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director After this certificate has been signed by the attending physicial completed filled in by the funeral director, page 2 should be detached for use as the but Medical Certificate: To Re Completed by Divisional Medical	5	4 Homicide	determi		28e. Place o buildin	of Injury g, etc. (/ - At horr (Specify)	ne, farm, s	treet, fact	ory, office				ocation (S lity or Tov		nd Number e)	o <i>r Rur</i> a	Route I	Number,
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the H ithin 24 orthe F		only one) 3 29b. Signature and ti	☐ Certifying	Nurse Pra	actioner: T	o the be	est of my l	knowledge	death oc	curred at th	e time, da	ate and pla	at the tir ace, and	ne, date a due to th	e cause	(s) and man	ner as st	ated.	
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	1	30. Name and addre	ss of person w	ho comp	leted cause	of dear	th (Item 2	23a) (Type,	Print)				0 1						
State		JUIS RE	Day, Year)	LERC	32 Ro	CBS	Signatu	INAT	H	SPITA	72	OF.	SHO	TIM	701	25			
State Registrar		31. Date filed (Month	N21	2010	32 Re	wa.	Jugitato	. 1	and a										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month DOROTHY TOOHEY SCHULTZ ŽÖ,2010 January 6:05A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death St Elizabeth Nursing Center Baltimore Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Month, Day, Year)
January 8, 1949 Months Days Hours Director <u>215-48-3456</u> Maryland Usual Residence of Decedent "natural", or items 23a or 28a-f show idical Examiner must be notified at 10a. State 10b. County should be filed within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director 1 ☐ Yes 🏋 No Maryland Howard Glenwood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 14502 MacClintock Drive 21738 USA Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 XX No Black, White, etc. Completed by 1 Never Married XX Married Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes XX No Specify. White 3 - Widowed 4 - Divorced Specify Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important. If item 27 is marked other than "natur any injury or other traumatic event, the Medical any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Engineer Manufacturing æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ |Frank Winter Toohey Dorothy Simms 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harry Lee Schultz III Husband 14502 MacClintock Drive Glenwood Maryland 21738 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) **XX**Burial 2 ☐ Cremation 3 ☐ Removal from State Donation 5 Other (Specify) Crestlawn Memorial Gardens Jan 23,2010 Sykesville, Maryland 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc nature of Funeral 6500 York Road Baltimore Maryland 21212 23a. Part 1. Enter the disease, or complica shock, or heart failure. List only one ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Immediate Cause (Final disease or condition resulting in death) Orset and Death Ischemic Cardiomyopathy Physician/ Medical Due to (or as a consequence of): Examiner Multiple Sclerosis Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Anxiety Depression 1 ☐ Yes XX No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? Yes 2XX 1 Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 🏋 ✗o æ 26. Place of Death (Check only one) Hospital: Other: XX Nursing Home 5 - Residence 6 - Other (Specify) ျ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred XXVatural 5 Pending iniury Accident 1 Tes 2 🗀 No Investigation after death Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical Karage Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D55391 January 20,2010 30. Name and address of person who completed cause (Item 23a) (Type, Print)
Ming Yi, MD 3320 Benson Avenue Baltimore, Maryland 21227

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

JAN 2 1 2010

Registrar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of Maryland / I	Department of Hea Certificate of De		al Hygien Reg. N	2010	01222
			Decedent's Name (First, Middle, Last)			ate of Death		3. Time of Death
	Physici /Medi		Irma Irene Samargo			_	Day Year L6 2010	06:05 AM
	Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Loc	cation of Death	4	c. County of Death	
-			Knollwood Manor		rsville		Anne Aru	
1	Funeral Director		212 22 2470		Under 24 Hrs. 8. D. Hours Min. (A May	ate of Birth Nonth, Day, Yea 29 19		lace (State or Foreign stry) MD
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	the 1	rec	10e. Street and Number	10f. Zip Code	n Burnie	10g. 0	Citizen of What Coun	itry?
	death with the Maryland rms 23a or 28a-f show rmust be notified at	Funeral Director	6646 Whitmore Court Unit 140	2.3	1061		USA	
	death	ner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispa If Yes, specify Cuban, N	anic Origin? (Specify Y	es or No-	14. Race - Americ	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modeal Event in the intiffical at once.	Completed by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ Xho If Yes, Give Year or Dates:		Specify:	, etc.)	Black, White, e	
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2	iled w Hygie ther t	ပိ	17. Father's Name (First, Middle, Last)	Cashie	r 3. Mother's Name <i>(Firs</i>		ntomobile	Body Shop
an	d be feet ental	Be c	William Myers		,			
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Baltimore,	permit. Departr Imports any Inju		21. Signature of Funeral Service Lice)see	22. Name and Address of 3111 Mounta:	of Facility St	allings	Funeral	Home, P.A,
	_		23a. Part 1. Enter the disease, or complication, that caused the death. Do				, FID ZIIZ.	Approximate
-	Physician /Medical		shock, or heart failule. List only one aute on each line. Immediate Cause (Final disease or condition resulting in death) a.		ASCULAR]) SEASE	-	Interval Between Onset and Death
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Records, F	uires that the de signed by the a Id be detached f	ğ	Part II. Other significant conditions contributing to death but not resulting in	n the underlying cause given ir	n Part I. 2		o use contribute to th 2 No 3 Prob	ne cause of death?
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jo	ath. ar: Af	atio	2 Accident investigation		2 □ No			
Division of Vital	al or Atte s after de il Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, fa building, etc. (Specify)	rm, street, factory, office	28f. Lc	ocation (Street a lity or Town, Sta	and Number or Rura ate)	l Route Number,
lo	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge 2 Medical Examiner: On the basis of examination are and manner stated.	e, death occurred at the time, and/or investigation, in my opinion	date and place, and d ion, death occurred at	ue to the cause the time, date a	e(s) and manner as s and place, and due to	stated. the cause(s)
W	To the To the COTE	ž	29b. Signature and title of certifier	29c. License nu	umber	29d. D	Date signed (Month,	Day, Year)
			I am Cowallow ung	731131	6	JA	NUARY 19	2010
			30. Name and address of person who completed cause of death (Item 23a) BRIAN C- WALLACE, Wid), 90	(Type, Print) 205 GLBL 1 DE	E RD, BAI	(MORE	, aun 212	36
	Sta Registr		30. Name and address of person who completed cause of death (Item 23a) BRIAN C. WALLACE WW, 90 31. Date filed (Month, Day, Year) 32. Registrar's Signature	have		1		

10-00412

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

Johnny Siganoff, J	r. S	tate of Maryla		ment of iicate of	Health an	d Mental	Hygiene	gible.	0.1000			
Physician	Registrar 1. Decedent's Name (First, Midd	dle,Last)		icale of	Dealli		2. Date of De	Reg. No.	3. Time of Death			
Medical Examine	Johnny Paul S	Siganoff					Month January	Day Year 14, 2010	1319 hrs			
	4a. Facility Name (if not instituti Johns Hopkins Hospi		mber)	4k	. City, Town, or Baltimore	Location of D	eath	4c. County of Deat N / A				
Funeral	5. Social Security Number	6. Sex	7. Age (In yrs. last I	birthday)	If Under 1 Yea			irth (MM/DD/YYYY) 9. Bir	thplace (State or			
Director	UNK	1 M 2 F		Yrs.	Months Day		Min. Oct.	29, 2009 Co	ountry) MD			
any	Usual Residence of Decedent 10a. State 10b. County		10c. City, Tox	wn or Location					10d. Inside City Limits			
*	MD N		100. 0.13, 100		ltimore				1 X Yes 2 No			
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	10e. Street and Number 609 01d Ham	Street			10f. Zip Code			10g. Citizen of What Cou United Sta				
leath with the ritems 23a or ust be notifical Uneral Di		12. Was Dec	edent Ever in U.S.	13. Was	Decedent of His	spanic Origin?	(Specify Yes or No					
er death with v. or items 23 r. must be no	1 X Never Married 2 M	larried Armed Fo	orces? 2 X No	If Yes	, specify Cubar	n, Mexican, Pue	erto Rican, etc.)	No- 14. Race - American Indian, Black, White, etc.				
s after ral", uniner	3 VVidowed 4 Div	vorced If Yes, Give Year or Dates:			es 2 X No				ite			
2 hour "natu	15. Decedent's Education (Spe Elementary/Secondary (0-12)			a. Decedent's during mos	Usual Occupat t of working life	tion (Give kind DO NOT use	of work done retired)	16b. Kind of Business/	ndustry			
21215-0036 ulid be filed within 72 hour Mental Hygiene. marked other than "nature event, the Medical Exan	N/A				N/A			N/A				
215-(215-(be filed vintal Hygoriked oth ent, the		. ,					ame (First, Middle, Eany Cham	,				
212 tould by d Ment s mark fic ever			11	19b. Mailing A	ddress (Stree			mber, City or Town, State	, Zip Code)			
MD and 2 sho alth and m 27 is aumati	Johnny Sigano	off, Sr	Father	609 01	d Ham S	treet,	Baltimor	e, MD				
Ore, ges l ar of Hee If ite	20a. Method of Disposition 1 X Burial 2 Cremation	n 3 Removal fro	crem	atory or other	on (Name of cer place)	· I	Date	20c. Location - City or	· · · · · · · · · · · · · · · · · · ·			
Baltimore, permit. Pages 1 at Department of He. Important: If ite	4 Donation 5 Other Si 21. Signature of Puneral Service	pecify:	ric.		emetery		-19-2010	neral Home,	, Maryland			
Ba perm Dept	I Dean De	Wildell		271	9 Hammo	nds Fry	y Rd., La	insdowne, MD				
Physician √Medical	23a. Part I. Enter the disease, or failure. List only one cause	complications that ca	used the death. Do nchioliti	not enter the	mode of dvina	such as cardia	ic or respiratory arr	est shock or heart	Approximate Interval Between Onset and			
Examiner	Immediate Cause (Final disease or condition resulting in death)	a associ	ated with						Death			
	Sequentially list conditions,	b										
ted Insit Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	cause. Enter Underlying Cause (Disease or injury that initiated c										
d d ansit	events resulting in death) Last	Due to (or as a d.	consequence of):									
be executed iician and urial - transit	X UNPENDED		a,27,28a-	f norm	F ~901	2/21/	10 TT					
760, icate big the bus	IF FEMALE: 23b. Was decedent pregnant in th	23c. If yes, o	utcome of pregnanc	у У	E, 8301	3/31/.	10 11	23d. Date of delivery				
Box 68760, e death certificate by the attending physic of for use as the burned by sician/Mec	past 12 months?	Live bit	rth ant at time of death	2 Fetal 5 Other	death 3 (Specify)	Ectopic preg	gnancy	Month D	ay Year			
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Division of Vital Records, P.O. B tal or Attending Physician: The law requires that the d rs after death. Tal Director: After this certificate has been signed by the led in by the funeral director, page 2 should be detached ertification: To Be Completed by Physician in the function of the completed by Physician of the completed by Physician of the complete of the complet	Part II. Other significant conditi	fons contributing to	death but not resulti	ing in the und	erlying cause gi	ven in Part I.	23e. Did to	bbacco use contribute to t	he cause of death?			
ords, P w requires to should be o					.,		24a. Was a		opsy findings available			
Records, The law requirer ficate has been signage 2 should be Completed							autop perfor	prior to comed? death?	ompletion of cause of			
tal Recician: The Learnificate Pector, page	25. Was case referred to medical				26.Place	of Death (Chec	1 Yes :	2 No 1 Yes	2 No			
f Vital Physician r this cert al directo	examiner? 1 ✓ Yes 2 No	Hospital. 1 In	patient 2 🗹 ER/0	Outpatient 3	DOA	Other Nur	sing Home 5	Residence 6 Other:	T-1			
n of ding Ph	27. Manner of Death		f Injury 28b Day,Year)	. Time of Injui	·	at Work?	28d. Describe h	now injury occurred				
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Division o ospital or Attending hours after death. meral Director: Aft y filled in by the fune Certification:	3 Suicide 6 X Could deter	d not be mined (Specify)	Found:			maing, etc.	Baltimo	Street and Number of Run tate) 609 01dha Ore, MD	m St			
0	29a. Certifier 1 Certifying Ph	nysician: To the best	of my knowledge, de	eath occurred	at the time, dat	e and place, a	nd due to the cause	e(s) and manner as state	d.			
To the Howithin 24 To the For completel	29b. Signature and title of certifie	and manner sta	ated.	investigation	29c. License		at the time, date a	and place, and due to the				
	his his	NA			O.C.N			January 15, 2010	ri, Day, Year)			
N/	30. Name and address of person		, , , ,					•				
V	1	nt Medical Exam	6	n Street,	Baltimore, N	1D 21201						
State Registrar	31. Date filed (Month) (A) (P2)	1 2010 32 Reg	strar s Signature	he	Kall							
DHMH 17 Rev 1/2001 OCMF 2006			OF	RIGINAL			0	CME				

10-00323 Margaret Stellma	nn	Please Type or Print in BI State of Maryland					ible.				
Margaret Stemma		- For State	•	ate of Death	nu wentai n		2010	01221			
Physicia		Registrar 1. Decedent's Name (First, Middle,Last)				2. Date of Death	, No.	3. Time of Death			
Medical Examir	ner	MARGARET DABNEY STELLMANN				Month January 11		1822 hrs			
)		 Facility Name (if not institution, give street and number) 3040 Black Rock Road 		4b. City, Town, Upperco	or Location of Death	4c. County of Death Baltimore County					
Funeral	-		e (In yrs. last bir		ear If Under 24Hrs	s. 8. Date of Birth	(MM/DD/YYYY) 9. Birt	<u> </u>			
Director		212-60-9924 _{1 M 2} XX _F 46			ays Hours Min	_					
	ı	Usual Residence of Decedent									
ow any		10a. State 10b. County	10c. City, Town	or Location				10d. Inside City Limits 1 Yes 2 XX No			
ryland ra-f sho	g	Maryland Baltimore Upperco 10e. Street and Number 10f. Zip Code 10g. Citizen of What Cou									
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show a injury or other traumatic event, the Medical Examiner must be notified at once.	Director	3020, Black Rock Road	õ	1377	USA	·					
with ms 23.	uneral	11. Marital Status 12. Was Decedent	pecify Yes or No- Rican, etc.)	14. Race - Americ	can Indian, Black,						
or ite	퇿	1 Yes 2	lo specify:	racan, oto.,		hite					
urs afte	흵	Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade con	npleted) 16a.	Decedent's Usual Occup		work done	16b. Kind of Business/Ir				
72 hou "nai	e e	Elementary/Secondary (0-12) College (1-4 or s	5+)	during most of working li	fe. DO NOT use ret	ired)					
DO3(within iene. Medic	Completed	4	- (Fi-A B4: Jake B4	Media							
15-17-17-17-17-17-17-17-17-17-17-17-17-17-	Be	17. Father's Name (First, Middle, Last) Henry Carrington Lancaster	e (First, Middle, Ma Gillespie f	•							
212 ould by 1 Ment 1 mark	일	19a. Informant's Name/Relationship (Type, Print)		Moiling Address (Str.	eet and Number or	Rural Route Numb	er, City or Town, State,	Zip Code)			
MD id 2 sh illth and m 27 is aumaf		<u> </u>		120 Black Rock							
Ore, ses 1 ar of Hea If ite		20a. Method of Disposition 1 XXBurial 2 Cremation 3 Removal from Sta	cremat	of Disposition (Name of d tory or other place) Nas Cemetery	110		20c.Location - City or T Dwings Mills,				
ltimit. Pagirtment	Ц	4 Donation 5 Other Specify: 21. Conature of Funeral S Licensee	St mai				efeld Funeral				
Ba perm Depa Impe		SIMMO DUNKEN (KPM)	(RIA)				, Maryland 212				
Physician	7	23a. Part I. En er the disease or complications that caused failure. List only one vuse on each line.	the death. Do no	ot enter the mode of dyin	g, such as cardiac o	or respiratory arres	t, shock, or heart	Approximate Interval Between Onset and			
/Medical Examiner				f anorexia ı	nervosa/b	ullimia		Death			
a sagarini vigospija	-	or condition resulting in death) Due to (or as a consection of the condition of the condit	equence or):								
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OX 68760, eath certificate be e attending physicial for use as the burial	sician/Med	3b. Was decedent pregnant in the past 12 months?	2	Fetal death 3	Ectopic pregna	ancy		ay Y ear			
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O. Bo at the de d by the		Part II. Other significant conditions contributing to death	but not resulting	g in the underlying cause	given in Part I.	23e. Did tob	acco use contribute to t	he cause of death?			
ords, P.O. **requires that the speed signed by should be detach	ed by		 			1 Yes		ably 4 🗹 Unknown			
cord law req has been	Completed					24a. Was an autopsy perform	prior to co	opsy findings available ompletion of cause of			
tal Rectian; The l	S.		_			1 ✓ Yes 2		2 No			
Vital I hysician: this certifi	a	25. Was case referred to medical examiner? Hospital: 1 Inpatie	nt 2 ER/O	utpatient 3 DOA	Other Nursir		esidence 6 🗸 Other:	Scene			
n of Ving Phy	<u>ان</u>	27. Manner of Death 28a. Date of Injury	ry 28b.	Time of Injury 28c. In	jury at Work?		w injury occurred				
ion of trending Pt death stor: After	atio	1 X Natural 5 Pending 2 Accident Investigation	,	1	Yes 2 No						
Division of Vital Records, ospital or Attending Physician: The law require hours after death meral Director: After this certificate has been siy filled in by the funeral director, page 2 should by	Certification:	Suicide Getermined (Specify)	iury - At home, fa	arm, street, factory, office	building, etc.	28f. Location (Str or Town, Sta	eet and Number or Rur te)	al Route Number, City			
hou hou		29a. Certifier 1 Certifying Physician: To the best of m	/ knowledge, dea	ath occurred at the time.	date and place, and	I due to the cause(s) and manner as state	d			
To the Hos within 24 h	Medical	one) 2 Medical Examiner: On the basis of examiner and manner stated	nination and/or i	nvestigation, in my opinio	on, death occurred a	at the time, date ar	nd place, and due to the	cause(s)			
- + * + °	ž	29b. Signature and title of certifier	1	2	nse number	د ا	29d. Date signed (Mon				
		Theodon Ill. King J	Ry m	0.0	.M.E. 00101	lou	January 12, 2010				
XI		 Name and address of person who completed stude of d Theodore M. King, Jr., MD. Assistant M 		iner 111 Penn S	treet, Baltimor	e, MD 21201					
Sta	ate	31. Date filed (Molth, RayGest) 2010 32 Registral	's Signatur								
Regist	rar	JAN 21 2010 Clever	v p.	parke							

Amend 20a-c, Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2017 Mamie L. Sparrow /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Franklin Square 5. Social Security Number Rosedale HOSPHAI CONTOR Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral Days Hours Min. 1 □ M 2 € F Yrs. Director No. Carolina 239-46-8790 Feb 7, 1934 Usual Residence of Decedent with the Maryland 10d Inside City Limits 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar. Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it at Medical Examinat must be notified at any injury or other traumatic event, it at Medical Examinat must be notified at any once. 1 Yes 2 No Director N/A Baltimore Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3411 Shannon Drive 21213 U.S.A. by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 11 Marital Status 1 Never Married 2 Married □Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify. Specify. Black 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Holiday Inn Housekeeper Sparrow, Marnic 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Naomi Nelson Mason Cocks ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3411 Shannon Drive Baltimore, Maryland 21213 Patricia Shannon 20c. Location - City or Town, State Baltimore, Date 20a. Method of Disposition 20b. Place of Disposition (Name of Metro Crematory or other place) 1 ☐ Borial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lansdowne, Maryland 01/26/10 Mt. Zion Cemetery 21. Signatur o Fund I Service Li de see 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Futaw Place Battimore, Md 21217 23a. Part 1. Eyer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pulmonary Due to (or as a consequence of): **Physician** 2 years /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last and burial-trar Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Pregnant at time of death 5 ☐ Other (specify) □Yes 2□No been signed by the should be detached 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an has autopsy performed his certificate h I director, page 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this nours after death.

neral Director: After this y filled in by the funeral di 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide e Funeral I 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely and manner stated. To the I within 2 To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 18/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Soubre Drive Baltimore, MD 21237 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month 08 Day **Physician** 21.00 PM SPENCER JARRISON 01 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ARLINDEL GLEN BURNIE MARLEY NECK HEALTH AND REHAB CENTER If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month. Dav. Year) **Funeral** Days Min 1 ☑ M 2 ☐ F Director Maryland 90 Feb 24, 1919 218-05-0410 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Exemirer must be notified at 1X Yes 2 No Director **Baltimore** N/A Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21225 U.S.A. 4111 Audrey Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∏Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No 1941 1 ☐Yes 2 🙀 No \$ Specify: Black 3 ₩ Widowed 4 □ Divorced 1945 Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Longshoreman Hygiene. permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If item 27 is marked other the any injury or other traumatic event, the angles. Gangleader 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ada Spencer Samuel Spencer ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4111 Audrey Avenue Baltimore, Maryland 21225 Theresa M. Jordon 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 01/19/10 Crownsville, Md. 4 ☐ Donation 5 ☐ Other (Specify) Crownsville Veterans Cemetery 21. Signature of Functal Service Lice 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 0 Approximate Interval Between Onset and Death 23a. Patt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) HYPERTENSION **Physician** /Medical Examiner PROSTATE HYPER TROPHY Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) EMENTIA Due to (or as a consequence of): burialphysician URINARY TRACT Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 I Unknown signed | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 RENAL INSUFFICIEN CY 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performed? 1 Yes 2 No certificate 25. Was case referred to medical director Be 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natura 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Physician: The law requires that the death certificate be executed Box 68760 P.0. Records, of Vital Division Hospital or Attending n 24 hours after death.

• Funeral Director: A

pletely filled in by the f. death.

Maryland 21215-0036

Baltimore,

Medical completely within 2 State Registrar

4 | Homicide

(Check only

29b. Signature and title of certifier

29a. Certifier

M.D LNL 3233 SUPERIOR 821

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

DHMH 17 Rev 1/2001

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D0058580

BOWIE MD 20715

29d. Date signed (Month, Day, Year)

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Physician/ 55 PM SMITH 1205E TANUAR Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BAYVIEW MEDICAL CENTER HOPKINS If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 💢 F Ancon Canal Zone Director Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 1 Yes 2 No more 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number iral", or items 23a or Examiner must be Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1. Yes 2 No Specify. If Yes, Give Year or Dates "natural", 3 Divorced Completed permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical once. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry life, DO NOT use retired) Elementary/Seconday (0-12) Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ 19a. Informant's Name/Relationship (Type, Print) (daughter 19b. Mailing Address (Street and Number or 20a. Method of Disposition 20b. Place of Disposition (Name of Date crematory or other place, Burial 2 Cremation 3 Removal from State 12010 4 Donation 5 Other (Specify) of Fureral Service Lice see 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 4 225SI disease or condition resulting in death) CARLIN PULM ON ART Medical Examiner 1445 Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of, attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed SE12016 that initiated events Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Year Day Pregnant at time of death been signed by the should be detached 1 ☐ Yes 2 ☐ 9 ☐ Unknown a 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy death? Yes 2 No After this certification funeral director, p **Sivision of Vital** Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 1 ☐ Yes 2 ☑ No ျ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending injury within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certife 29c. License number RES-000 13,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD, PhD AGBOR-ENDH ENUE

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 01228 Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JÄNÜARY 20°1′0 LORRAINE SACHS 4:40 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6 UPLAND ROAD. #C BALTIMORE N/A If Under 1 Year If Under Social Security Numbe 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. 1 🗆 M 2 💢 F Months Days Hours 88 Yrs Director 216-20-3159 Usual Residence of Decedent "natural", or items 23a or 28a-f shov edical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD BALTIMORE N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21210 72 hours after death with 6 UPLAND ROAD. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black. White, etc. δ 1 Never Married 2 Married 2 X No ☐ Yes Maryland 21215-0036 1 ☐ Yes 2 No Specify. If Yes, Give 3 Midowed 4 □ Divorced Specify: Completed WHITE Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) marked other than College (1-4 or 5+) 5+ Elementary/Seconday (0-12) INTERIOR DESIGNER DESIGN Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ MEYER BLANKMAN ROSE SELENSKI and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Heatth ar Important: If item 27 is any injury or other trau MORTON BLANKMAN / BROTHER UPLAND ROAD, #J4, BALTIMORE, MD 21210 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burlal 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) SHAAREI TFILOH CONG. 1/20/2010 WOODLAWN, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 Mel 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Lond Pflysiciall/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) The law requires that the death certificate be executed and -trans that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Day g Unknown Division of Vital Records, P.O. signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy perform certificate To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Residence 6 Other (Specify) Director: After this d in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Ďescriba how injury occurred 5 Pending Natural 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined hours after City or Town, State) within 24 hours a

To the Funeral C

completed filled Medical 29a. Certifier certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature 29c. License number 18

Registrar

State

31. Date filed (Month, Day, Year)

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of person who com

10755 FALLS RD, SUITE 200 LUTHERVILLES MI

2109-

cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month OR mes Medical give street and number) 4a. Facility Name (if not institution, Examiner 4b City Town or Location of Death 4c. County of Death l a 0 . Age (la yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. Director Usual Residence of Decedent ortant: If Item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director 10a, State with the Maryland 10d. Inside City Limits 1 Yes 2 □ No 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? Funeral 5009 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 14. Race - American Indian Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. filed within 72 hours after of ģ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No If Yes, Give Year or Dates Specify: 3 ₩idowed 4 □ Divorced Specify: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) borer Oth Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Earl aborn Page 1 and 2 should nent of Health and Me Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) madeira 54. Department of Health Important: If item 27 Baltimore, Method of Disposition 20b. Place of Disposition (Name of 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 20-2010 Catonsville 4 Donation 5 Other (Specify) remator Signature Funeral prvide Lie ed any 23a. Part . Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show or heart failure. List only one cause on each line. Approximate Interval Between Immed are Cause (Final Onset and Death Physician/ Atherosclerotic Coronary or condition Medical resulting in death) Due to (or as a consequence of): Examiner pertension Securatially list conditions if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed andiomyopath attending physician and for use as the burial-tran Due to (or as a consequence of Physician/Medical ulmonary Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year signed by the aid be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ hypothyroidism diabetes 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed dementia tibrillation 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy cancer anemia performed Yes 2 death? within 24 hours after death.

To the Funeral Director: After this certificate 2 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 2 No 1 Inpatient 2 ER/Outpatient 3 I DOA funeral (28a. Date of injury (Month, Day, Year) Certificate: Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1_Natural 5 Pending 1 Yes 2 No 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier ' Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0062735 January 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) Loch Raven Boulevard Baltimore, 21239 Aparna Jonnal 5601 31. Date filed (Month, Day, Year) 32. Registrar's Signatu State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For Amend It	State of Ma em 1 per d	arylan r.,g8	d / Depa 8 99,01	rtment of 25/2010 tilicate of	Health a De ath	and Me	ntal Hyg	giene Reg. No. 20	10	01231
			1. Decedent's Name (First, Middle, La	st) Georgean	na	Tyler			2	. Date of Dea		.,	3. Time of Death
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-	//wedic Examin		4a. Facility Name (If not institution, give	ve street and number)	.	-	4b. City, Town,	or Location o	of Death	0 /	4c. County	of Death	1 0 11/
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	P.		Usual Residence of Decedent										
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	a-f s	cg	MD N/A			Ва	ltimore						1 ∏Yes 2 □ No
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21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show with highly or other traumatic event, the Medical Evanuar must be notified at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Tyes 241 N If Yes, Give Year or Dates:			Vas Decedent of fYes, specify Cul ☐Yes 2☐Woo			fy Yes or No- can, etc.)	14. Race Black Specify:	, White,	can Indian, etc. hite
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altimore, Maryland	and 2 sho ealth and n 27 Is mi		19a. Informant's Name/Relationship (Andrew G.Jersey -		aw						er, City or Town, S		o Code)
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Ĕ	permit. Pages Department of Important: If it any Injury or o		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Special		M	eadowr emoria	Ptory or other pla L Park	1	-19-2	010	Elkridge	e, M	D
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J.	that hed by deta	/ Phy	Part II. Other significant conditions	contributing to death bu	ıt not resu	ulting in the un	derlying cause gi	ven in Part I.		23e. Did to	bacco use contri	bute to t	he cause of death?
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	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical C	29a. Certifier (Check only one)	nysician: To the best of miner: On the basis of and manner sta	examina	wledge, death tion and/or inv	occurred at the restigation, in my	ime, date an opinion, deat	nd place, an occurred	d due to the	cause(s) and maddate and place, a	nner as s	stated. o the cause(s)
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•	N.		30. Name and address of person who	completed cause of de	ath (Itam	1 23a) (Tyne F	Print)	1115)		1-17-	20	10
	40 /		Michael D Witti	A A A	_22	S C	ביר אי פיל פיל ביר אי פיל פיל	S + T.	2014	1010	np 12-	1	21201
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year 55 A-M **Physician** 1acl OR 15 actedit 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner HUE Baltimore Spring dale Baltike RE If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2 □ F Months Days Hours 刻334 7225 Director 38 VA Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Masteral Examiner must be notified at 10a. State 10b. County 1 ☐ Yes 2 ☐ No Director MD NA Baltimore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21216 by Funeral 3600 Springdale Ave U.S.A. filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married Married Baltimore, Maryland 21215-0036 1 □Yes 2X No Specify: Specify: Black 3 Widowed 4 Divorced Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10th grade Security Guard B & Green Wholesale 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Brewer Eleanor Taylor 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any Injury or other trainonce. Betty Taylor-Wife
20a. Method of Disposition B600 Springdale Ave, Baltimore, Md 21216
lace of Disposition (Name of Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ariel Crossroads 1/23/10 Marion, SC 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, 21. Signature of Funeral Service Licensee Baltimore, Md 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Kielowal Viscase Stage Physician hrovie 8 MODHES /Medical Due to (or as a consequence of) Examiner VOCEL abetes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): al or Attending Physician: The law requires that the death certificate be executed as after death.

I Director: After this certificate has been signed by the attending physician and d in by the funeral director, page 2 should be detached for use as the humal-transit 4 acex 3 -20510 D !ty per Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No Month Day Year 5 ☐ Other (specify) 9 I Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 2 No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death?
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2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only XCRDT 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier RO51063 Marilery 30. Name and address of person who completed cause or death (Item 23a) (Type, Print) 3900 Lock Ravas Blod Blg 2 Baltonons MD2125 Mareroon Kalloy Chist 32. Registrar's Sign State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #1, per MD g900 2/11//10 TT/ #20b Per FH. C900 2/19/2010 WS State of Maryland / Department of Health Pand Mental Hygiene Reg. No. 2010 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Thompson PM Roman G. Thompson, Jr. 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Season's Hospice Randallstown Year) 32 If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, 05 13 Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Funeral 77 MD 215-30-3930 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examination and the natural as Director MD Baltimore Randallstown 1 ☐ Yes 2 XNo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3801 Schnoper Drive Apt 114 21133 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Armed Forces?

1 XYes 2 □ No
If Yes, Give
Year or Dates: Black White etc 1 Never Married 2 Married Saltimore, Maryland 21215-0036 Black 1 ☐Yes 2X No Specify Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 12th grade College (1-4or 5+) Civil Service Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mammie Roman Thompson Sr. ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeanne Hitchcock-Cousin 5882 Pimlico Road, Baltimore, Md 21209 Owings Mills 20a. Method of Disposition Date Ukn 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4⊟Donation 5 ☐ Other (Specify) 2/3/2010 Garrison Forest Vet: Signatur- Filmeral Service Licensee 22. Name and Address of Facility March F/H West 4300 Wabash Ave, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21215 Baltimore, Md Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** End-Stage Cartiony upathy / /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician certificate be Physician/Medical the nse If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Por Month in the past 12 months? Day Year 5 Other (specify) □Yes 2□No ed by the a 9 Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy certificate 1 ☐ Yes 2 ☐ No the Hospital or Attending Physician: completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this Certification: To 27. Manuer of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 V Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) nskijapamenio. D005746S 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, MD. 21209. N.S. RappakeMD 2835 Smith Av., Suite Zo3 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature State Registrar Down S. Back

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 5240A M 2. Date of Death Physician/ 2010 Takako Treasure Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 5 Baltimore Washington Medical Center -N M-2 WY If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 □ M 2 🖾 F Days Months Hours Min. OCL Day 3 Country) ^(ear)1933 Director 550-62-7399 75 Japan Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 2 No Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 235 Arundel Road 21122 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 14. Race - American Indian Completed by 1 Never Married 2 5 Married 1 ☐ Yes If Yes, Give 2 🖾 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ₺ No Specify: Specify: 3 Widowed 4 Divorced White Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DC NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Household 12Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unknown Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John H. Treasure 235 Arundel Road, Pasadena, MD 21122 (spouse) 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metro Crematory Inc. 20a. Method of Disposition 20c. Location - City or Town, State Date 19 1
Burial 2
Cremation 3
Removal from State Baltimore, MD 2010 4 Donation 5 Other (Specify) Signature of Funeral Ser 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only due cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exami that initiated events Due to (or as a consequence of): resulting in death) Last burial-1 attending physician for use as the burial Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be IF FFMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Records, P.O. Box in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate 2 **X** No 1 Yes Yes completed filled in by the funeral director, 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) examiner? Other: 4 \(\to \) Nursing Home 5 \(\to \) Residence 6 \(\to \) Other (Specify) 1 🗌 Yes ၉ 1 Inpatient 2 I ER/Outpatient 3 I DOA 24 hours after death.

Funeral Director; After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 🗌 Yes 2 🗌 No Investigation Could not be Accident 3 Suicide
4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier (Check within 2 only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. and title of 29b. Signatur who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person DK 31. Date filed (Month, Day, Year) Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death la Month Physician/ 152PM OII Medical City, Toy 4c. County of Death **Examiner** Medica TIMOX If Under 1 Year If Under 24 Hrs.

1 House I Davs Hours Min. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🔀 M 2 🗆 F 4 Director e of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at within 72 hours after death with the Maryland Funeral Director 1 XYes 2 ☐ No more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? d Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Bace - American Indian. 11, Marital Status Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: 3 ₩idowed 4 □ Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business Industry al Hygiene. life. DO NOT use retired Elementary/Seconday (0-12) permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 Is marked othe any injury or other traumatic event, Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ 19a. Informant's Name/Relationship (Type, Print) (doug ter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 2010 4 Donation 5 Other (Specify) Signature ral Service Licens 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition Tos Approximate Interval Between Onset and Death Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Infection Examiner Sequentially list conditions iner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) Pregnant at time of death 2 No After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown 9 Unknown ignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an 24 hours after death.

Funeral Director; After this certificate has autopsy death? 1 ☐ Yes 2 ☐ No Yes Hospital or Attending Physician: 25. Was case referred to medical examiner?
1 ☑ Yes 2 ☐ No Vital Be 26. Place of Death (Check only one) Hospital Other: 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manne of Death Division of Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one 29d, Date signed (Month, Day, Year) 29c. License number son who completed cause of death (Item 23a) (Type, Print) Registrar's Signature State Registrar DHMH 17 Rev 7/2009

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ January Robert E. Wittlinger 2010 1:35 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Howard 8609 Goldenstraw Lane Columbia 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 XM 2 □ F Months Days Hours Min. Mar 11, Year 942 Pennsylvania 67 Yrs **Director** 182-34-3445 Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2X No Columbia Howard Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21045 **USA** 8609 Goldenstraw Lane Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. Completed by 1 Never Married 2 Married Yes 2 X No 72 hours after Maryland 21215-0036 Specify: White 1 ☐ Yes 🎇 ☐ No Specify: If Yes, Give "natural", 3 Widowed 4 Niporced Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than " Elementary/Seconday (0-12) College (1-4 or 5+) Vice President & General Manager Packing Distribution Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Carl R. Wittlinger Dorthey E. Gast 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1252 Prizer Road Pottstown, PA 19465 Steve Wittlinger, Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State injury or 4 Donation 5 Other (Specify) Metro Crematory Inc. 101/20/10 Baltimore, Maryland 21. Signature of Funeral Service Licensee Thomas Gregor MemariAddesSofFacillety Of Maryland, Inc. 99 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Inset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical ue to (or as a conseque ce of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) the burialattending physician for use as the burial Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death Day 2 🗆 No g Unknown 9 Unknown P.O. | by signed k Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 nknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy After this certificate Yes Division of Vital director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မြ 1 Inpatient 2 ER/Outpatient 3 DOA filled in by the funeral 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? injury within 24 hours after death

To the Funeral Director: A
completed filled in by the fi death. ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the 29b. Signature and title of ce 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed use of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day, Year

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 2010 Baby Boy Williams Januari /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Baltimore Birthplace (State or Foreign Country) Social Security Number If Under 24 Hrs. 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 1 X M 2 □ F Months Days Hours Min Jan 11, infant 2010 Maryland Usual Residence of Decedent 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits 1 □Yes 2 □ No Director MDBaltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1121 Punjab Drive #3 21221 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1X Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify. Specify: black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) infant infant infant infant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ovid Devries Khadtjah Williams ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Franklin Square Hospital 9000 Franklin Square Drive Rosedale, MD 21237 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5₩Other (Specify) in state 21. Signature of Funeral Surv State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part | . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or cordition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of). resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 🗀 Ectopic pregnancy in the past 12 months? Month Year Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) 1 □Yes 2 🖬 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Tyes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1□ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide

Box 68760, o σ. Division of Vital Records,

The law requires that the death certificate be execu physician attending the signed by t I be detach s certificate has bodiector, page 2 s' or Attending Physician; After this within 24 hours after death.

To the Funeral Director: A completely filled in by the fu To the Hospital

Funeral

Director

show

7 is marked other than "natural", or items 23a or 28a-f shor traumafic event, the Modical Examiner is ast be nothed at

n and Mental Hygiene.

permit. Pages 1 and 2 Dep. rtment of Health a Imp. rtant: If item 27 is any injury or other tra once.

Physician /Medical

Examiner

and

use as the burial-tran

ρ

detached

director,

funeral

State Registrar

Medical

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

ong

29a. Certifier

(Check only one) 29b. Signature

who completed cause of death (Item 23a) (Type, Print)

TV Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and magner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month Year ам <u>Brenda</u> :00 Medical Mae Wheeler 2010 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 3201 Avon Avenue Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Days Hours (Month, Day, Year) 8-5-1947 1 □ M 2 😾 F 226-72-8057 62 Director Usual Residence of Decedent 10a. State 10b. County iral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD na Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3201 Avon Avenue 21218 US Α 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Black, White, etc. þ 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates. Maryland 21215-0036 1 ☐ Yes 2X No Specify: Black "natural", Specify: Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the Disabled Disabled Department of Health and Mental Hygier Important: If item 27 is marked other to any injury or other traumatic event, the once. <u>12th grade</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Jimmy Frederick Olivia Stevenson 19a. Informant's Name/Relationship (Type, Print) Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Allen G. Wheeler, 3201 Avon Avenue Balto, MD 21218 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Burial 2 \square Cremation 3 \square Removal from State 4 \square Donation 5 \square Other (Specify) King Memorial Pk 1-22-2010 Randallstown, 21. Signature of F heral Service Licensee 22. Name and Address of Facility March East F/H - Meller 1101 North Avenue 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Physician Methothers disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) physician and the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Pregnant at time of death Day Year signed by the a Id be detached for g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe page this certificate 1 Yes Yes 2 Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 🗆 10 Other: 1 Tes 욘 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury Natural injury 5 Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 1 Ves 2 No Accident M Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of cert

DHMH 17 Rev 7/2009

Registrar

2

30. Name and address of

West 40th Suite 400

completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Maryla		partment of F <i>ertificate of I</i>			giene Reg. No. 2 (010	0 1	239
			Decedent's Name (First, Middle, Last,					Date of Dea Month	ath	Vacx	3. Time	of Death
	Physici /Medic		JAMES WILHE	FLM SK.				Oi	Day	2010	3:5	74 AM
	Examin	er	4a. Facility Name (If not institution, give		0		Location of Death	^		nty of Death	10 (110	
- APR	Funeral		ANNE AZUNDEL MI 5. Social Security Number 6. Se				ANNAPOLI If Under 24 Hrs.	8 Date of Birt	h	9. Birth		te or Foreign
ı	Director		212-28-6910]M 2□F 78	Yrs	Months Days	Hours Min.	09-30-	1931	Coui	ntry) M	_
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or	Location				1	10d Inside	City Limits
	Maryl.	tor	MD Harford		-	t Hill						es 2 X INo
	h the	Director	10e. Street and Number			10f. Zip Code			10g. Citizen o	of What Cou	ntry?	
	23a c		202 Kimary Ct #20			21050	0		US	A		
	er de items	Funeral	The state of the s	12. Was Decedent Ever in U Armed Forces?	J.S. 1	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Spe ın, Mexican, Puerto I	cify Yes or No- Rican, etc.)	14. R	ace - Ameri lack, White,		
5-0036	urs aft	þ	1 ☐ Never Married 21 Married 3 ☐ Widowed 4 ☐ Divorced	1 ∏ Yes 2 ∐ No If Yes, Give Year or Dates:		1 □Yes 2XNo	Specify:		Spec	cify: Wh:	t e	٠.
2-0	72 hours after death with the Maryland "natural", or items 23a or 28a-f show they Evant net must be notified at	Completed	15. Decedent's Edu (Specify only highest grad	cation	16a. De	cedent's Usual Occup	ation	na	16b. Kind of	Business/In	dustry	
2121	filed within Hygiene. sther than "	ldu	Elementary/Secondary (0-12)	College (1-4or 5+)		ive kind of work done on DO NOT use retired ice Office		.9	Balti	more (lity	
0	is 1 and 2 should be filed within of Health and Mental Hygiene. item 27 is marked other than "other traumatic event, Italy was	Be Co	17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle,				
lan	ould be Mental arked o	To B	John A. Wilhelm				Elizabeth	A. Wa	1sh			
lar,	2 should I and Men is marke aumatic	1	19a. Informant's Name/Relationship (Ty	pe. Print)	1	ailing Address (Street			,		Code)	
e) S	1 and Health Health Her to	1		Wife)		Kimary Ct		est Hil			04-4-	
Mor	Pages nent of I int; if ite		20a. Method of Disposition 1X Burial 2 □ Cremation 3 □ P 4 □ Donation 5 □ Other (Specify)	emoval from State		sposition (Name of rematory or other plac Valley	e) 01-22-	-2010	20c. Location	•	,	
Baltimore, Maryland	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service License			22. Name and Addres	ss of Facility Sch	Lmunek :	Funera.	1 Home	of :	BelAir
	TO = 60		23a. Part 1. Enter the disease, or compli	Cellon	th. Do not	Inc 610 W				MD 21	LO14 Approxin	nato
	Physician	i s	shock, or heart failure. List only or Immediate Cause (Final	ie cause on each line.	41 /04			respiratory ar	rest,		Interval I Onset ar	Between nd Death
	/Medical		disease or condition resulting in death)	Due to (or as a conse	quence of):	DIAC INM	RCTION				1 170	NR
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	ted nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	quence of):							
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98760	ificate be executed physician and is the burial-transit	edical										
_		Med	IF FEMALE:									
Ž R R	requires that the death certifi seen signed by the attending nould be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	3c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of	al death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	/		1	ate of deliv	ery Day	Year
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<u> </u>	artifica ctor, p	BeC	25. Was case referred to medical examiner?				26. Place of Death			1 □ Yes	2 ∐No	
010	hysic this ce al dire		1 ☐ Yes 2. No	ospital: Inpatient 2	T		4 LI Nursing Hor	ne 5□ Resid	ence 6 🗆 C	ther (Specia	fy)	
on o	ding F h. After funera	tion:	27. Manner of Death 1. Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year)	28b. Time Injur	y Work	yat :? Yes 2 □ No	8d. Describe h	ow injury occi	urred		
Mision	Atten r deat ector: by the	ifica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At h	iome, farm,			8f. Location (S	treet and Nur	nber or Rura	al Route N	umber,
S	ital or its afte ral Dir led in	Certification: To	4 Hornicide	building, etc. (Spec			V.	City or Tow				
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page.	edical	29a. Certifier (Check only one) Certifying Physical Examination (Check only one)	sician: To the best of my kn ner: On the basis of examin and manner stated.	owledge, de ation and/or	eath occurred at the tir investigation, in my o	ne, date and place, a pinion, death occurre	and due to the o	cause(s) and date and place	manner as s e, and due to	stated. o the caus	e(s)
	To th To th comp	Me	29b. Signature and title of certifier	5		29c. License		2	29d. Date sign	ned (Month,	Day, Year)
•	2DV	-	20 Name and address of	Jacq	00-\ (T		6753		1/	19/10		
	7		30. Name and address of person who co	Carstack, 20	of Me	dical Parkw	ay, Anna	wis 1	WD 21	401		
	Stat Registra		31. Date filed (Month, Day, Year) JAN 2 1 2010	32. Registrar's Sign	ature	Ne.	('	V				
						W						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 16 2010 Year JANUARY WISNIEWSKI 10:40 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death FOREST HILL HARFORD FOREST HILL HEALTH & REHABILITATION Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 91 Days Hours Min. (Month, Day, Year April 18. 1**X**□ M 2 □ F 215-09-7163 Director Maryland Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must he matified at 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits Director Harford Darlington 1 ☐ Yes 2 No Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21034 4201 Paddrick Road USA 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 XYes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: White If Yes, Give Year or Dates. Specify: 3 ₺ Widowed 4 □ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Carlins Black Label Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Agnes Cierniak Anthony Wisniewski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Darlington, Md. 21034 4201 Paddrick Rd. Joanne Restauro Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) 1-18-2010 Balto.Md. Bayview . Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home Mannon Closenove 610 W. MacPhail Rd. BelAir, Md. 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Mespera Medical Due to (or as a consequence of): Examiner VA Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): Examin The law requires that the death certificate be executed the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Box 68760 use as yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 5 Other (specify) Month Day signed by the and be detached for P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 1 Yes 2 No 3 Probably Completed Were autopsy findings available prior to completion of cause of 00 24a. Was an page 2 autopsy perform Yes 2 death? certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica Division of Vital 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) 1 Yes 2 No Other: ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) D32299 JANU/ Am 13, 201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

DAVID DUNN

JAN 21 2010

31. Date filed (Month, Day, Year)

32. Registrar's Signatur

615 W. MACPHAIL ROAD - BEL AIR, MD 21014

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item s 20b, c per fh g900 2-8-10 yt State of Maryland Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Year 15 PM 2010 Ernest J. Ward Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore N/A Union Memorial Hospital 6. Sex 1 □ M 2 □ F 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) '. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Months Days Hours Director 219-38-7760 Dec 7, 1941 Maryland Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 nows with a population of Health and Mental Hygiene.

Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show important: If Item 27 is marked other than "natural", or items 25a or 28a-f show important: If Item 27 is marked of the world in the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Marvland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2816 Denham Circle 21225 U.S.A 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: 3 Widowed 4 Divorced Completed Year or Dates Black 1967 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Private Company 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Ernest B. Ward Ada Ward 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karolyn Ward 2816 Denham Circle Baltimore, Maryland 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 S Buriel 2 Cremation 3 Removal from State Date Baltimore Sonation S Other (Specify) 01/40/10 Crownsville, Md. Crownsville Veterans Cemetery 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as carriac or respiratory arrest, 23a. Part 1 Approximate Interval Between Onset and Death shock. or heart failure. List only one cause or each line. Fastromtestral Bleed Immediate Cause (Final Physician, disease or condition resulting in death) OLIOURS Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or injuthat initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Month Year Day Pregnant at time of death Unknown Yes 2 No s been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed I 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No has e 2 page After this certificate funeral director, pag 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No Other: ၉ 1 Yes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier 1 🔽 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier ATZY 389 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Moniorial Hospital, Baltimore, MD Union Meirk OUNG 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** lliams 14,20 /Medical 4c. County of Death 4a, Facility Name (If not institution, give street, and number) 4b. City, Town, or Location of Death Examiner more ta Under 1 Year | If Under 24 Hrs 5. Social Security Number 9. Birthplace (State or Foreign Country) 6. Sex . Age **Funeral** Months Hours Min. 225-38-8248 1 □ M 2 🗸 F Days **Director** Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show or other traumatic event, the Medical Evandmer must be notified at MD timore 1 Mes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? than "natural", or items 23a USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc 1 ∐Yes 2**X** If Yes, Give Year or Dates: 1 Never Married 2 Married 2X No 1 ☐ Yes 2 No Specify: Completed by 3 ₩ Widowed 4 Divorced Decedent's Usual Occupation (Give kind of work done during most of working life: QO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Baltimore, Maryland 2121 condary (0-12) Health and Mental Hygiene. permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If Item 27 Is marked other than any Injury or other traumatic event, Its once. 17. Eather's Name (First, Middle, Last) Name (Firşt, Middle, Maiden Surname) 18_Mother's Informant's Name/Relationship (Type. Print) Aural Route Number, City or Town, State, Zip Code) 19b. Mailing Address lvin Myron Williams 21217 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5 Other (Specify) 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to, (or as a consequence of) Examiner ypernatre Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed burial-trai Due to (or as a consequence of) Box 68760, attending physician Physician/Medical as IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 TEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Year 5 Other (specify) P.0. detached 9 Unknown 9 Unknown cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown Completed certificate has been . Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No Division of Vital 1 ☐ Yes 2 No 1 ☐ Yes completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 No 24 hours after death Funeral Director: 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specity) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Keydy

Registrar

State

31. Date filed (Month, Day,

JAN 21 2010

32. Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death .Month Physician 2010 org anua /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 24 Hrs. 8. Min. 8. Date of Birth (Month, Day, Age (In yrs. last birthday, 9. Birthplace (State or Foreign Sex 120 M 2 □ F **Funeral** Months Days Hours Director 1591 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hydene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination and once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 XYes 2 ☐ No Director more 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No <u></u> 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Ctr. Manager Balto City button 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Date 20a. Method of Disposition 20c. Location City or Town, State 1 💢 Burial 2 □ Cremation 3 □ Removal from State 2010 4 □ Donation 5 □ Other (Specify) 21. Sonature Fun ral Service Licen e neral Ba Home 216 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Phermonia week /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician; The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Month Year signed by the a 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by page 2 should be 4 Unknown Dementia 3 Probably 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certificate has been completely filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Dysphagia autopsy performe 2 **N**0 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manuar of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 \(\text{Homicide} \) 29a. Certifier i 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number Res ecc ed cause of death (Item 23a) (Type, Print)

State Registrar Caliatan JAN 21 2011

DHMH 17 Rev 1/2001

Sinai Hospita

240 | w. Bel redere Ave. Baltimore MD 21215

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician/ 223 AM ona Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harbor 1timore 05 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Funeral 9-26-1949 Days 1 X M 2 🗆 F Months Hours Min MD **Director** 60 217-56-3006 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at Director Brooklyn Park MD Anne Arundel 1 ☐ Yes 2x X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò Funeral 23a USA 345_Cresswell Rd 21225 items 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian 11. Marital Status Armed Forces?

1 XXYes 2 No
If Yes, Give
Year or Dates. If Yes, specify Cuban, Mexican, Puerto Rican. etc. Black, White, etc. ¥₭ Never Married 2 ☐ Married ō þ Maryland 21215-0036 1 Yes 2 No Specify. White "natural", 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Transportation 12 Delivery Driver Be should be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental 2 Catherine R. Huer James M. Aberts 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is 565 Pasture Brook Rd, Severn, MD 21144 Daughter niece Baltimore, 1 Donna Swan 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removar from State injury or 4 Donation 5 Other (Specify) Crownsville Veterans Cem Jan 25, 2010 Crownsville, MD 21. Signature of Reneral Service License 22. Name and Address of Facility
Fink Funeral Home, P.A. any 426 Crain Hwy S. Glen Burnie. MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Pharyngea Ph_sician/ cascinoma Squamous disease or condition resulting in death) Medical Due to ras consequence of): Examiner Sequentially list conditions. Examine if any, reading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of that the death certificate be executed attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death 2 No ed by the a g 🗌 Unknown g Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hospital or Attending Physician: The law requires 2 ☐ No 3 ⚠ Probably 4 ☐ Unknown 1 🗌 Yes Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed this certificate pertensión 1 ☐ Yes 2 ☐ No mia Yes 2 25. Was clase referred to medical examiner?
1 🔯 Yes 2 🗆 No funeral director, To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After of completed filled in by the funeral 1 Natural 5 Pending Division 1 Yes 2 No Investigation Accident 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) more, MD 21225 anover 31. Date filed (Month, Day, Year) 32. Registrar's State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Alice M. Butler	F	1- For State Registrar		of Maryland		artment o tificate o		d Mental		g. No. 201	0 01245
Physiciar Medical Examin	n/	1. Decedent's Nam	e (First, Middle,Last)			•			2. Date of Deat Month January 16	Day Year	3. Time of Death 0734 hrs
		4a. Facility Name (if not institution, give	street and number	-)		4b. City, Town, or Baltimore	Location of Dea		4c. County of Dea	ath
Funeral Director		5. Social Security I 213-84-	-7946 ₁□	7. A	ge (In yrs. la	ast birthday) Yrs	If Under 1 Yea Months Days		8. Date of Birt	h(MM/DD/YYYY) 9. E	Birthplace (State or eign Country) MD
any		Usual Residence o 10a. State	f Decedent 10b. County		10c. City,	Town or Local	ion				10d. Inside City Limits
ryland a-f show	Director	MD 10e, Street and Nu	NA mber		Ba	ltimor	E 10f. Zíp Code		110	g. Citizen of What Co	1XXYes 2 No
h the Ma			arren Av				212	230		USA	
her death wit ", or items 2 er must be n	Fune	11. Marital Status 1 Never Marri 3 Widowed	ed 2 Married	12. Was Deceden Armed Forces 1 Yes 2	et Ever in U.	If Y	as Decedent of His es, specify Cuban Yes 2 No	, Mexican, Pue	White, etc.	erican Indian, Black, African erican	
36 .n 72 hours af san "natural lical Examin	Completed by	15. Decedent's Edementary/Second 12th G1	ducation (Specify onlondary (0-12)	or Dates:		16a. Deceder during m	nt's Usual Occupatost of working life	ion (Give kind o DO NOT use r		16b. Kind of Busines Hospit	s/Industry
		17. Father's Name	(First, Middle, Last) in R. Yoame/Relationship (Ty					18.Mothers Na	me (First, Middle, M	laiden Surname) tler	
MD 21 d 2 should lth and Me n 27 is man	۱۹		me/Relationship (Ty Hodge - F							ber, City or Town, Sta	
nore, MD 2 ages I and 2 shou nt of Health and I nt: If item 27 is r other traumatic		20a. Method of Dis			tate	Place of Dispos crematory or ot	ition (Name of cer her place)	netery,	Date	20c. Location - City	
Baltimore, permit. Pages I a Department of He Important: If ite injury or other t	Ī		Other Specify:	ее	I Me		Gremator Name and Address 8 N. Gi				wille, MD Home P.A. e, MD 2121
Physician /Medical	1		ne disease, or con lingly one cause on each	h line.		Do not enter t	he mode of dying,	such as cardia		est, shock, or heart	Approximate Interval Between Onset and Death
Examiner		or condition resulti	ng in death)	ue to (or as a cons							
	edical Examiner	Sequentially list co if any, leading to in cause. Enter Unde (Disease or injury)	nmediate Derlying Cause c	ue to (or as a cons							
e be executed e be executed ysician and burial - transit	al Ex	events resulting in	d.			.7.					_
60, ate be ex hysician hysician		IF FEMALE:		AMENDED 23 23c. If yes, outco	Ba,27	28a-f,	permE, g	900 2/5	/10 TT	23d. Date of delive	ery
Records, P.O. Box 68760, The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be dehached for use as the burial - transition of the control of the	sician/l	23b. Was decedent past 12 months		1 Live birth	t time of de	2 Fe	tal death 3 [her (Specify)	Ectopic preg	nancy	Month	Day Year
ords, P.O. It werequires that the sbeen signed by the should be detached.	≙	Part II. Other signi	ficant conditions	contributing to dear	th but not re	esulting in the u	underlying cause g	iven în Part I.		bacco use contribute to 2 ✓ No 3 Pr	to the cause of death?
Division of Vital Records, is a or Attending Physician: The law requirers after death. *A Director: After this certificate has been signed in by the funeral director, page 2 should be the control or the control of t	Completed								24a. Was a autops perfor	sy prior to med? death?	
	å	25. Was case refer examiner?	Ho	ospital: 1 Inpati	ent 2	ER/Outpatient		of Death (Chec	ck only one)	Residence 6 Oth	er.
Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifi completely filled in by the funeral director.	tion: To	1 Ves 27. Manner of Deal 1 Natural	5 Pending	28a. Date of Inj (Month, Day,)	ury Year)	28b. Time of I	njury 28c. Injur	y at Work?		ow injury occurred	
Division ospital or Att. hours after de uneral Directory filled in by the	Certification:	2 Accident 3 Suicide 4 Homicide	6 X Could not b determined	28e Place of I	njury - At ho		et, factory, office b	uilding, etc.	28f. Location (S	treet and Number of Pare, Baltimore,	Rural Route Number, City ren Ave MD
To the Hospital within 24 hours: To the Funeral completely filled		29a. Certifier (Check only one) 2	Medical Examiner:		amination a					e(s) and manner as stand place, and due to	
E S E 8	₽	29b Signature and	title of certifier	Lill	-		29c. License O.C.I			29d. Date signed (Manuary 17, 20	
		30. Name and odd Margarita K	ess of person who co	ompleted cause of sistant Medical			enn Street, B	altimore MI	21201		
Sta Registr	~	31. Date filed (Mon		_		parket	•				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Valter Blucher		- For State Registrar	St	ate of Maryla		irtment o tificate o		nd Mental		2 eg. No.	010	0124		
Physician Medical Examine	1/	1. Decedent's Name Walte		B 1 uche	r				2. Date of Dear Month January 1	Day Y	'ear	3. Time of Death 1014 hrs		
		4a. Facility Name (if Northwest H		on, give street and nu	ımber)		4b. City, Town, o RandalIsto		eath		y of Death ore Coul	nty		
Funeral Director	2	5. Social Security N 2 1 7 – 80 – 8	046	6. Sex XXM 2 F	7. Age (In yrs. Ia	ast birthday) Yrs	If Under 1 Ye Months Da		N. C.	firth (MM/DD/YYYY) 9. Birthplace (State or Foreign Country) MD				
r any	-	Usual Residence of 10a. State	Decedent 10b. County		10c. City,	Town or Locat	ion					10d. Inside City Limits		
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ith the Maryland 23a or 28a-f sho notified at once		116 Wi1	gate		edent Ever in U.	0 140 144		117			U.S.			
or items 23a or 28a-f sh	Laurer	1 Never Marrie		arried Armed F	orces?	If Y	es, specify Cuba	an, Mexican, Pue	(Specify Yes or No- erto Rican, etc.)	Wh	ite, etc.	can Indian, Black,		
natural",	⋧┞		lucation (Spe	orced If Yes, Give Yes or Dates: 3 cify only highest grad	de completed)	16a. Deceder	Yes 2XXNo It's Usual Occupa ost of working life	ation (Give kind				hite ndustry		
y, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland eath and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-fahr traumatic event, the Medical Examiner must be notified at once TO Be Completed by Eingeral Director	ourpiered	Elementary/Seco		College (1	-4 or 5+)		luce Ha			Gro	cery			
21215-0036 Juld be filed within 7 Mantal Hygiene. marked other than c event, the Medica	ונ	17. Father's Name (John W.		cher, Jr	•				e Mae Wh		•			
MD 2121 d 2 should be fi lth and Mental n 27 is markee rumatic event,	2	19a. Informant's Nad Barbara		hip (Type, Print) . 11 / Sis	ster		•		or Rural Route Num Pikesvi1					
S E E		20a. Method of Disp	osition	3 Removal fr	om State 20b. P	rematory or otl		-	Date	20c. Location	•			
Baltimore, permit. Pages I at Department of He Important: If ite	1	4 Donation 5 21. Signature of	Other SprakSeptice	pecify: Licensee	Met	22. N	lame and Addres	s of FacilitEC		unera	1 Cha	apel P.A.		
Physician	-	23a. Part I. Enter the failure. List only		complications that con each line	aused the death.							Approximate Interval Between Onset and		
Examiner		Immediate Cause (F or condition resultin	· Final disease	a. Acute	myocard		arction				-	Death		
		Sequentially list con if any, leading to imi cause. Enter Under	mediate	b. Due to (or as a	consequence of):					-			
ted nisit	Ya	Disease or injury the events resulting in c	at initiated	,	consequence of):								
0, e be executed ysician and burial - transi	- E	X UNPENDED		AMENDED	#12, pe 23a,27,p	er ME g	900 2/12 900 2/4	2/10 TT /10 TT						
ox 68760 eath certificate is attending physion use as the busing of the certificate is a strictly or the certificate in the cer	2	F FEMALE: 3b. Was decedent p past 12 months?		23c. If yes, (outcome of pregn	iancy	tal death 3		gnancy	23d. Date of Month	of delivery Da	ay Year		
). Box 6876(the death certificate by the attending phy ched for use as the behave in any Macinian/Mac	200	1 Yes 2 N		4 Pregn	ant at time of dea	ath 5 Ott	ner (Specify)			1		i		
P.C	3	Part II. Other signif	icant condit	ions contributing to	death but not re	sulting in the u	nderlying cause	given in Part I		bacco use con 2 ✔ No		ne cause of death?		
Division of Vital Records, isl or Attending Physician: The law requires its after death. al Director: After this certificate has been sighed in by the funeral director, page 2 should be artification: To Be Commisted.	ואומומ								24a Was a autops	sy		opsy findings available empletion of cause of		
tal Rectinant The certificate ector, page		25. Was case referre	ed to medical		<u>_</u>		26.Plac	e of Death (Che	1 ✓ Yes 2		1 🗸 Yes	2 No		
ion of Vital lending Physician: eath. for: After this certifule funeral director, the funeral director, artion: To Be eath	2	27. Manner of Death	No No	28a. Date	npatient 2	ER/Outpatient 28b. Time of I		Other ₄ Nur ury at Work?	rsing Home 5 1	Residence 6				
Division ospital or Attending tours after death. neral Director: Aft filled in by the function:		1 Natural 2 Accident		ing tigation	Day Year)	me farm stree		Yes 2 No	28f Location (S	treet and Num	her or Dur	al Route Number, City		
		Suicide Homicide Sea Certifier		d not be mined (Specify)	o or injury - Acrio	mo, iami, stree	it, factory, office t	ballang, etc.	or Town, St		Jei oi Kuiz	ar Notice Number, Only		
To the Hospi within 24 hour To the Funer completely fill		Check only		nysiclan: To the bes miner: On the basis of and manner st	of examination an									
	2	29b Stgnature and t	itle of certifie	1/18	Jeak!	M850	29c. Licens O.C.	M.E.		29d. Date sig January 2		th, Day, Year)		
D.	3	Name and addre		who completed caus Assistant Me		,	enn Street, E	Baltimore, M	D 21201					
State Registra	_	31. Date filed (Month	n, Day, Year) N 2 2		gistrar's Signatur	ba	KN							
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 9:23 81 Henrietta Bartecki 2010 /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner aceHaso Tal imore 0 If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 1-12-1920 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Days Hours Min Months 1 □ M 🛂 F MD 217-16-4082 90 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 28a-f show Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Redical Examiner must be coeffied at 1√2 Yes 2 No Director Dundalk MD Baltimore 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code 21222 USA 8151 Mid Haven Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after 1 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural"; or iter any Injury or other traumatic event, the Medical Examiner once. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify. þ Specify: White 3 Nidowed 4 Divorced Maryland 21215-00: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Bag Assembler Manufacturing 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Unknown Kurlinski Unknown Kurlinski 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8151 Mid Haven Road, Dundalk, MD 21222 Anna Holewinski - Niece Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 A Cremation 3 ☐ Removal from State Bayview Crematory 1-20-10 Baltimore, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Bradley-Ashton Funeral Home 21. Signature of Funeral Service Licensee PA, 2134 Willow Spring Road, 21222 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** AAA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events.) Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical attending I 23c. if yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Year Day 4 ☐ Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 🗌 Yes 2 🗍 No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 s autopsy performed? 1 □ Yes 2 No this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1XYes 2□No 1 Inpatient မှ 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No thin 24 hours after death.

the Funeral Director: / 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) within 2 29b. Signature ar of certifie 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

#308 Baltimos

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 01248 Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year racy King Boyer 1950 M 10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Planters MD Keedysville ane 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 X M 2 □ F Days Hours 181-16-9674 88 Dec 10, Director 1921 Pennsylvania Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ed other than "natural", or items 23a or 28a-f show event, the Medical Examination to ust be notified at Director MD Washington Keedysville 1 ☐ Yes 21 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 18731 Planters Lane 21756 USA Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 2 □ No 1 ☐ Yes 2 No Specify: 2 Specify: white 3 Widowed 4 Divorced 43-46 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "n any injury or other traumatic event, the Medione. College (1-4or 5+) Elementary/Secondary (0-12) minister clergy 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Flossie Joy Tracy Carl King Boyer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Grace Boyer/spouse 18731 Planters Lane Keedysville, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 21. Signa ure of Funeral Service License Romald, S. W. 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 in 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Immediate huse (Final disease or condition resulting in death)

a. The to (or as a consequence of): Approximate Interval Between Onset and Death **Physician** reard /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): the burial-transit and Due to (or as a consequence of): signed by the attending physician d be detached for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☐ No Year Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by contractures OF 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 2 □ No 1 □ Yes 2 □ №6 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🛂 🗖 0 Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending

Hospital or Attending Physlcian: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

completely filled in by the funeral director, page 2 should be detached after death.

Director: After this certificate e Funeral within 2

> State Registrar

2 Accident 3 Suicide

4 Homicide

(Check only one)

29b. Signature and title of certifier

29a. Certifier

ical

investigation

6 Could not be determined

Hospice Cynthia Kuttner-Sands, MD €2. Registrar's Signature

thea Kuther-Sand, no

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐Yes 2 ☐No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Avenue

28f. Location (Street and Number or Rural Route Number, City or Town, State)

of Washington County, 747 Northern

29d. Date signed (Month, Day, Year)

Hagerstown, Maryland 21742

Tanuary 15, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ BROWN WATNE JA NUTICE ICCO M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Good Samaritan Hospital 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Days Mar 18, Year) 950 1 🕅 M 2 □ F Hours Min. Country) unk 58 Director 218-56-2335 Usual Residence of Deceden permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner months. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 ☐ Yes 2x No MD Baltimore Parkville 10f. Zip Code 10e, Street and Numbe 10g. Citizen of What Country? Funeral 8720 Emge Road 12. Was Decedent Ever in U.S. unk 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status unk Armed Forces?

1 Yes 2 No Black, White, etc. Completed by 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify Specify: black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry unk (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) unk Be 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) unk ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Good Samaritan Hospital 5601 Loch Raven Blvd Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🗌 Burial 2 🗎 Cremation 3 🗌 Removal from State 4 ☐ Donation 5 🗓 Other (Specify) in state 21. Signature of Funeral Se 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Viractor. Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Interval Between Onset and Death Aseur Physician/ disease or condition resulting in death) Brown Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death nse 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death cate has been signed by the a page 2 should be detached to 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably Value Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Hospital Other: Yes 2 🗆 No ER/Outpatient 3 DOA 1 Inpatient 21 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 5 Pending Natural 1 Yes 2 No Investigation Accident Suicide
Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined Medical 🕆 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical Examiner. On the basis of samination and a strong state of the cause (s) and manner as stated.

 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d Date signed (Month, Day, Year) VANNARY, LL, 2010 0018230 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Good Samanlan Horjital My 21236 SHASHIDHARAN, M.D 31. Date filed (Month, Day, Year) JAN 22 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 16:46 TANYARY 2010 Florine M. Bailey Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Hospital Samo-riton 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 0ct 20, 1923 9. Birthplace (State or Foreign Funeral Months 1 ☐ M 2 🔀 F Maryland 86 **Director** 219-12-1504 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d, Inside City Limits 10a. State 10b. County 10c. City, Town or Location death with the Maryland Director 1 √2 Yes 2 □ No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2901 E. Strathmore Avenue 21215 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11 Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married ğ Maryland 21215-0036 hours after 1 ☐ Yes 2 X No Specify: If Yes, Give white Completed 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 0 6 secretary Black & Decker Corp Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental F permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic ev Charles Levi Hilker Beulah Alverta Shaffer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2717 Coldstream Way Baltimore, MD William E. Bailey Jr/son Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 🗓 Donation 5 🗆 Other (Specify) 21. Si yratura of Funeral Source Licensee State Anatomy Board 655 W. Baltimore Street Baltimore MD art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease ondition Onset and Death congestive heart Pnysician/ Medical resulting in death) Examiner Urinory Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☑ No
9 ☐ Unknown Month Year 4 Pregnant 9 Unknown Pregnant at time of death been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 : autopsy performed? 1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No After this certific funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ဂ္ 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Matural 5 Pending injury in 24 hours after death.
The Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 the only one) within To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES - 000 2010 116

State Registrar 31. Date filed (Month, Day, Year)

JAN 22

Florine

Baltimore

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Good Samo niton Hespital

Maroz 5601 Lock Raven Blud

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month 01 Physician/ 20 2010 2:10 P Bueche ٧. Marie Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore Timonium Stella Maris Hospice If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔀 F Hours 0370571919 212-09-5071 90 Yrs. **Director** Baltimore, MD Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 X No Timonium MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21093 202 East Timonium Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forc Black, White, etc. 1 Never Married 2 Married Yes 2 X No δ Page 1 and 2 should be filed within 72 hours after Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: white Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Home Owner Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Not Known Navritil Julia Priborsky 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 Scotts Moore Court, Phoenix, MD 21131 19a. Informant's Name/Relationship (Type, Print) Robert Griffith/ Son-in-Law Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Dulaney Valley Mem. 1 K Burial 2 Cremation 3 Removal from State 1/23/2010 Timonium, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Towson, MD 21204 Inc. 1050 York Road Ruck Towson Funeral Homé, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph_sician/ CEREBROVASCULAR ACCIDENT Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause Enter Underlying Due to (or as a consequence of): Exami Division of Vital Records, P.O. Box 68760 the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 \(\sum \) Yes 2 \(\mathbb{X}\) No Day Pregnant at time of death 5 Other (specify) 4 ☐ Pregnant a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 5 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 1 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 \square Nursing Home 5 \square Residence 6 X Other (Specify) HOSPICE28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: injury 1X Natural 5 Pending 2 Accident 3 Suicide 4 Homicide Investigation within 24 hours after death To the Funeral Director. 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 X Certifying Nursa Practicular: The book of my hours by some formula of the film, date and place, and due to the cause(s) and manner as stated.

Registrar DHMH 17 Rev 7/2009

State

(Check

29b. Signature and title of certifier

JACKIE JONES,

JAN 2 2 2010

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registra

CRNP

2300 DULANEY VALLEY RD.

29c, License number

TIMONIUM, MD 21093

29d. Date signed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** CON 20/C /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Randallstown Baltimore Northwest Hospital 8. Date of Birth (Month, Day, Year) 04-06-19 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Days Hours Coun **1X**□M 2□F 90 Yrs. Director 212-14-2147 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any Injury or other traumatic event, the Westeal Examinar it ust be netitive at XXYes 2 □ No Director MD NA Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21207 USA by Funeral 3521 Meadowside Road 14. Race - American Indian,
Black, White, exfrican 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes 2 No Specify. Specify: American 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bethlehem Steel 11th Grade NA Welder 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Leon Chambers Anna Elizabeth Pierce Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5701 Gwynn Oak Avenue Baltimore, MD 21207 Leon R. Chambers, III 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State f Burial 2 ☐ Cremation 3 ☐ Removal from State 01 - 23 - 10Baltimore, MD Woodlawn Cem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Wylie Funeral Home P.A. 21. Signature of Funeral Service Licenses 638 N. Street Baltimore, Gilmor 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on aus, on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 1106disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): physician and s the burial-trans be exect Due to (or as a consequence of) Box 68760. Physician/Medical attending p for use as use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) P.O. I 1 Tyes 2 No the 9 Unknown þ signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division of Vital Records. ð 1 ☐ Yes 2 ☐ No Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t autopsy certificate 2 | No 1 □Yes 1 ☐ Yes To the Hospital or Attending Physician; 25. Was case referred to medical examiner? NOSDI Be 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient 5 Residence 6 Other (Specify) Certification: To After thi funeral of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation after death.

1 Director: Af 1 ☐ Yes 2 □ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 29a, Certifier TX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State

DHMH 17 Rev 1/2001

Registrar

30. Name and address of person who

31. Date filed (Month, Day,

e, Print

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RAY BLANCO MO 40/ TOUSDEN MD 2/204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrat Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year 9:46AM M 2010 HENRIETTA FRANCES COMES JAN 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) HARFORD BEL AIR UPPER CHESAPEAKE MEDICAL CTR Date of Birth (Month, Day, Year) Mar. 30,1924 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Social Security Number Min. 1 □ M 2 🖾 F Months Days Hours Mar. 218-80-6415 85 Maryland Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 21 No Maryland Harford Forest Hill 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2423 Rocks Rd. 21050 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2√XNo Specify. Specify: White X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 8 Vrs Housewife Housekeeping-Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Clara Alma Bryant John L. Thomas 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2423 Rocks Rd. Forest Hill, Md. 21050 Sandra Lee Comes (Daughter) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Burial 2 Cremation 3 Removal from State St. Ignatius Ch. Cem. 1-23-10 Hickory, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Name and Address of Facility Lassahn Funeral Home Tassann Funeral Home 7401 Belair R. Baltimore, Md. 6. 7 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Cardeac aur Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 No Month 4 ☐ Pregnant at time of death g ☐ Unknown 5 ☐ Other (specify)

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

Completed by

Be

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Examine

Be Completed by Physician/Medical

Certification: To

Medical

29b. Signature and title of certifier

the

completely filled in by

within 2

Hospital 24 hours a

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, I'm Medical Examinations.

Baltimore, Maryland 21215-0036

burial-transi Division of Vital Records, P.O. Box 68760 the as

sate has been signed by the attendir page 2 should be detached for use I or Attending Physician: The law after death.

Director: After this certificate has b

ing, Henrietta m8005214.

9 Li Unknown									
Part II. Other significant conditions of	ontributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown							
demetra		24a. Was an autopsy performed? 1 Yes							
25. Was case referred to medical	26. Place of Death (Check only one)								
examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home	e 5 ☐ Residence 6 ☐ Other (Specify)							
27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Year) Injury Work?	d. Describe how injury occurred							
3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	nysician: To the best of my knowledge, death occurred at the time, date and place, are								

29c. License number

29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

13

State

and manner stated

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Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2:45 RM 18, 2010 January Phillip Gordon Crews Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Center for Hospice Care Baltimore Towson 8. Date of Birth (Month, Day, Yes Apr 08, . Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Year) 1 935 1 M 2 □ F Months Days Hours ountry) Maryland Director 217-30-4711 Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location death with the Maryland event, the Medical Examiner must be notified at Director 1 Yes 2 No Harford Joppa 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 21085 United States 818 Chatfield Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian. 11. Marital Status Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. 0 þ 1 Never Married 2 Married filed within 72 hours after 1 Yes 2 SNo Specify: "natural", White Completed 3 Divorced 4 Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Il Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Beth. Steel Welder 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fishers is marked or ပ pe 1 Dora Kate North Robert Edward Crews, Sr. traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 shment of Health a tant: If item 27 is 818 Chatfield Road Joppa, MD 21085 Paula Crews /Wife other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) Jan 22 1 Burial 2 Cremation 3 Removal from State ò Department of Important: If any injury or once. Beltsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2010 Chesapeake Crematory 22. Name and Address of Facility
Cremation and Funeral Alternatives 21. Signature of Funeral Service Licensee M01443 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna Ectopic pregnancy in the past 12 months? Year Month Dav Pregnant at time of death
Unknown 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? After this certificate 6 2 🗌 No 1 Yes 1 🗌 Yes 2 🕼 No 25. Was case referred to medical To the Funeral Director: After this certific completed filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 2 No 1 Tyes ER/Outpatient 3 DOA 은 1 Inpatient 2 I 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d, Describe how injury occurred Hospital or Attending 24 hours after death. 1 Natural 5 \square Pending work 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

Registrar

State

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31. Date filed (Month, D

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

trar's Signature

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

POIN CHARLESST, SHITE 4105 BALTIMORE, MD 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year 10 Physician/ Month Irene Claypoole 20 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Good Samaritan Hospital Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 😿 F Hours Min. Mar 11 82 New York 219-22-8523 1927 Director Usual Residence of Decedent 23a or 28a-f show t be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Yes 2 No MD Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? er man "natural", or items 23a the Medical Examiner must be Funeral 21234 United States 7711 Park Dr. 12. Was Decedent Ever in U.S. Armed Forces?, 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumation. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Film Colorist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Charles Metz Irene Amelia Kamer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7711 Park Dr. Parkville, MD 21234 Robert Claypoole /Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition ^{Date} Jan 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Beltsville, Maryland 2010 4 Donation 5 Other (Specify) Chesapeake Crematory 21. Signature of Funeral Service Licensee 22. Nar@methaltrisonf Fastivit Funeral Alternatives Hackermon 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final -Physician/ Cancel disease or condition resulting in death) Ung Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) sician and burial-transit Exami death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician s the burial Physician/Medical attending p for use as 1 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months
1 Yes 2 No Month Year 5 Other (specify) Day Pregnant at time of death 1 Yes 2 is 9 Unknown been signed by the should be detached 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause give*n* i*n* Part I. 23e. Did tobacco use contribute to the cause of death? 2 Aeura Offusion Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Tracheal obstruction 24a. Was an has autopsy performed? 2 🗆 No 1 Yes Division of Vital or Attending Physician: 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? Other: 1 🗌 Yes 2 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) eral Director: After this filled in by the funeral di 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 Natural 5 Pending death. 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined hours after thin 24 hours a the Funeral Completed filled Hospital Medical 29a, Certifier 🔄 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the Pwithin 24 29b. Signature and title of certifier 0006521

State Registrar

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TIEM# 19a, per INF, G899, 1727/2010, WS

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. N. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day Year **Physician** MAG 3:05 p^M CCINA 01 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6406 Dahlgreen Ct. PG Lanham If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Min. 1 □ M 2 🖾 F Months Days Hours 78 Director 201-22-4108 10 1931 PA Usual Residence of Decedent 3a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1√2 Yes 2 No Director MD PG Lanham 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. th and Mental Hygiene. 7 is marked other than "natural", or items 23a traumatic event, the Pecical Examirer must b 6406 Dahlgreen 20706 USA Funeral Ct. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: Black δ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Administrator U.S. Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frederick D. Clark Dorothy Daniels ٩ 19a. Informant's Name/Relationship (Type. Print)
Denise Tucker / Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a permit. Pages 1 and 3 Department of Health Important: If item 27 any injury or other tr once. 311 Cainridge Dr. Clarksville, TN 37040 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metropolitan Alexandria, VA. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility MArshall's Funeral Home 21. Signature of Funeral Service Licensee MO0971 4217 9th. St. N.W. Washington, D.C. 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** TA ACUTE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Aleante Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit EMENTIA Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical UTERELD JAKOB 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 5 Other (specify) 1 ☐Yes 2 🗷 No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☒ No 24a. Was an after death.

Director: After this certificate has 1 in by the funeral director, page 2 s autopsy performe 1⊠Yes 2□No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No ٩ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? Medical Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 XX Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 24 hours af e Funeral D letely filled in 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou

To the Fune

completely fil 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b, Signature and title of certifier 29c. License number 40047494 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KOREST DR. ANNAPOLIS, MD CANGSTON MONIQUE 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician/ 4:48 PM aviness 2010 oki a Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Harbor HOSPITA Year If Under 24 Hrs. 9. Birthplace (State or Foreign CMarry Land 8. Date of Birth 7. Age (In yrs. last birthday) If Unde **Funeral** Novth, Day (Year) 1949 1 √2 M 2 □ F 60 216-50-2906 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location Director 1 Yes X No Lansdowne Baltimore 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? Funeral United States 21227 3235 Ryerson Circle 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. White Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 X Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Laurel Racetrack Horseman 8 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 Sandina Modo Sherman T. Caviness 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zio Code) 3235 Ryerson Circle, Lansdowne, MD 2122/ 19a. Informant's Name/Relationship (Type, Print) Thomas Caviness - Brother 20a Method of Disposition 20h Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)

Ceder Hill Cemetery Burial 2 Cremation 3 Removal from State 1-23-2010 Brooklyn, MD Donation 5 Other (Specify) 22. Name and Address of Facility Ambrose Funeral Home, Inc. Signature Funeral Service Lice 2719 Hammond Fry Rd., Lansdowne, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Davs disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate
Cause (Disease or iinjury ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical to the Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant Box (3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Month Year Day Yes 2 No 1 ☐ Yes 2 L 9 ☐ Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 □ Probably 4 □ Unknown 1 Yes Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has performed 1 ☐ Yes 2 ☐ No director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **N**0 욘 ☑ Inpatient 2 □ ER/Outpatient 3 DOA completed filled in by the funeral 27. Mar 28b. Time of 28c. Injury at work? ar of Death 28a. Date of injury 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 Watural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Defining Physician: to the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License numbe 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) St MD State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** 3:00 P^{M} 2010 January 15, Lucy Elizabeth Coram /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 2745 Red Oak Lane Lanham Prince George's If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Months 1 □ M 2X F 577-36-8667 81 Director Nov. 28, 1928 Virginia Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location show 10a. State ?? is marked other than "natural", or Items 23a or 28a-f shov traumatic event, the Modical Examinar must be notified at 1√2Yes 2 No Director Maryland Prince George's Lanham 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2745 Red Oak Lane 20706 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Iten any injury or other traumatic event, the Medical Examinations. Black White etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No 2 Specify: 3 Nidowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Housewife Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be (Unknown) Viola Young ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan V. Trimble-Coram (Daughter) 2745 Red Oak Lane, Lanham, MD 20706 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 1/22/2010 5 ☐ Other (Specify) Culpeper, VA 4 Donath Culpeper Nat'l Cemetery 22. Name and Address of Facility
Joynes Funeral Home, Inc. 21. Sign ture of Huneral Service Linens P.O. Box 3633, Warrenton, VA 20188 un 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Congres we /Medical o (or a bonsequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed Theros and burial-tran Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy signed by the atte Month Day Year 5 Other (specify) □Yes 2No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 □ Yes 2 No Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case r ferred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 27. Manner of Death 1 🕅 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide the Hospital or within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1525 GREENWAY CONTON DR HAL ASHA 31. Date filed (Month, Day, Year) 32. Registrar's Signatu State JAN 2 2 2010 Registrar

Division or Vital Records, P.O. Box 68760 To the Hospiu...
within 24 hours after
To the Funeral Dir

> State Registrar

29b. Signature and title of certifier

OULSEN MD 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 ANNAPOUS RD.

29c. License number

20645

ODENTUR MD.

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) 01261 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** M 408 CONTEH 2010 ALEXIS ESTHER /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner SILVER SPRING CROSS HOSPITAL MONTGOMBRY If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months, Days Hours Min. (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Year) 1□ M 2 🔽 F 17 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Wedical Examination with the indiffication. 1 Yes 2 No Director BURTONUL MONTGOMERY 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 2086 CKBURN Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No δ 3 Widowed 4 Divorced B4 C Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) NFANT CNEANS 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ NWK AGNES CONTEH 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) MD GLEN RD 401 CROSS HOSPITAL FOREST 120C 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4□Donation 5 MOther (Specify) in state ²² Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Signature of Funeral Service Licensee Baltimore, MD 23a. Part: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death

23 DAYS Immediate Cause (Final **Physician** a SUBDURAL HEMORRHAGE disease or condition resulting in death) /Medicai Due to (or as a consequence of): Examiner 27 AC OE EXTREMELY WO BIRTHWEIGHT Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine certificate be executed 23 WK GEST. EXTREME PREMISTURIT and burial-trar Due to (or as a consequence of): attending physician for use as the burial Division of Vital Records, P.O. Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) ☐Yes 2☐No the 9 Unknown 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed cate has been a page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy perform certificate 1 ☐Yes 2 No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 FOREST GLEN RD. S.S. MD HINE

DHMH 17 Rev 1/2001

State Registrar 32. Reg

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 18°, 2010 9:00 PMMae S. Collins January Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Montgomery Springhouse Manor Care Bethesda 9. Birthplace (State or Foreign If Under If Under 24 Hrs 8. Date of Birth Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 Year **Funeral** Days April 22,1923 Months Min 1 🗆 M 2 🖾 F Hours 087-20-5156 New York 86 Yrs Director Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Ħ Examiner must be notified Direct 1 Yes 2X No Maryland | Montgomery Bethesda 23a or 2 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20814 United States 4955 Battery Lane items 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14 Race - American Indian. 11 Marital Status Black, White, etc. ō by 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give 72 hours after Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🔀 No Specify: "natural" 3 ☑ Widowed 4 ☐ Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 multiply and Mental Hygiene. (Specify only highest grade completed) Government Printing Elementary/Seconday (0-12) College (1-4 or 5+) Librarian Office Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Clarence Schelleng Elinor Babcock 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) .. Page 1 and 2 shou tment of Health and tant: If item 27 is m 102 Edgewater Road, Narragansett, RI 02882 Robert D. Schelleng/Brother Department of Healt Important: If item 2 any injury or other 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of January 21, 2010 Monte one Tyror or other place)
Crematorium, Inc. 1 🔲 Burial 2 🔀 Cremation 3 🗆 Removal from State Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Robert A. Pumphrey Funeral Home Bethesda-Chevy Chase Inc. 7557 Wisconsin Avenu Bethesda, Maryland 20814 . Signature of Funeral Service 7557 Wisconsin Avenue 10 M01498 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ Atherosclerotic Cerebrovascular Disease disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): and the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical The law requires that the death certificate be Box 68760 IF FFMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Dav Pregnant at time of death cate has been signed by the page 2 should be detached 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Division of Vital Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No Yes 2 K No Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Assisted Living Other: 1 Yes 2 🖾 No 1 Inpatient 2 ER/Outpatient 3 IDOA ျ 4 Nursing Home 5 Residence this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: after death. Director: After injury X Natural 5 Pending 1 ☐ Yes 2 ☐ No To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number DOFACE January 19, 2010 H45839 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11119 Rockville Pike, #316, Rockville, Maryland 20852 Gary E. Raffel, D.O. 32. Registrar' Signat State 2 2010

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar	,	Ce	rtificate of	Death		Reg. No	2010	012	263
	Division		1. Decedent's Name (First, Middle, La	st)				2. Date of Do Month	eath Da	y Year	3. Time of	Death
	Physici /Medio		Marion S. Crow	nover				Januar			9:45	A^{M}
	Examin		4a. Facility Name (If not institution, giv			4b. City, Town, o		eath	4c.	. County of Deat		
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	Funeral		5. Social Security Number 6. S	□M 2XIE	last birthday) Yrs.	Months Days	Hours Mi	in. (Month, D	a <i>y</i> , Year)) Co	hplace (State o untry)	r Foreign
	Director		358-07-4784 Usual Residence of Decedent	91				May 8,	191	.8 111	<u>inois</u>	
	yland		10a. State 10b. County	10c. Cit	y, Town or Lo	cation					10d. Inside Cit	
	Mar.	Ş	Maryland Montgo	mery		Rockv	ille				1 ☐ Yes	2. No
	or 28	ire	10e. Street and Number			10f. Zip Code	_		10g. Ci	itizen of What Co	untry?	
	th will	al	4510 Landgreen St	reet			20853		Uni	ited Sta	tes	
	tems	Funeral Director	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	.S. 13.	Was Decedent of F If Yes, specify Cub	Hispanic Origin? an, Mexican, Pu	(Specify Yes or N erto Rican, etc.)	0-	 Race - Ame Black, White 		
36	s afte		1 ☐ Never Married 2 ☐ Married 3 🔀 Widowed 4 ☐ Divorced	1 Yes 2 No If Yes, Give Year or Dates:		1 □Yes 2 X No	Specify:			Specify:	h-14-a	
8	within 72 hours after death with the Maryland lene. than "natural", or Items 23a or 28a-f show he Medical Examithe method	Completed by	15. Decedent's Ed		16a. Dece	dent's Usual Occup	pation		16b. K	(ind of Business/	hite Industry	
215	in 72 i. in "ne	plet	(Specify only highest gra	ade completed) College (1-4or 5+)	(Give	kind of work done DO NOT use retire	during most of v	vorking			,	
212	d with giene er tha	E O	12	College (1-401 34)	Home	maker			Ow	n Home		
g	al Hy l othe	Be (17. Father's Name (First, Middle, Last,)			18. Mother's N	lame (First, Middle	e, Maider	n Surname)		
ylai	Ment Ment arkec	2	Jonathan Milner				Mary F	Robertson	l			
lar	2 sho	0.3	19a. Informant's Name/Relationship (Type. Print)	19b. Mailin	ng Address (Street	and Number or	Rural Route Numi	ber, City	or Town, State, 2	Zip Code)	
2	and Health m 27 her ti		<u>Janet Fefe / Dau</u>		4510	Landgree	<u>en Stree</u>			ocation - City or		<u>53</u>
Ö	ges 1 If of H If Ite or ot		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	cemetery, crei	sition (Name of matory or other pla		uary 23,	20c. L	ocation - City or	Town, State	
Baltimore, Maryland 21215-0036	t. Pa rtmer rtant:		4 ☐ Donation 5 ☐ Other (Special	TION.	gomery (Crematorium		010	Bet	hesda, N	laryland	<u> 1</u>
Bal	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Mydical Event from the rottlined at once.		21. Signature of Funeral Service Licer		260 30	Name and Address bert A. Pui O West Mont	mphrey Fu	neral Home	/Rock	ville, In	c. d 20850—2	2805
		ore)	23a. art 1. Enter the disease, or com							o, reitytein	Approximate	e
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T	Examiner											
	D ±	ner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conseq	uence of):							
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<u>0</u>	oe exe		resulting in death) Last	Due to (or as a conseq	uence of):							
68760,	eath certificate be executed attending physician and for use as the burial-transit	Medical		d			,				-	
9 ×	ding		IF FEMALE:	23c. If yes, outcome of pregna	ancv					Ond Date of do	li	
Вох	atten for us	cian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of	I death 3	☐ Ectopic pregnand ☐ Other (specify) _	су			23d. Date of de Month		Year
O.	The law requires that the death ate has been signed by the atter bage 2 should be detached for u	Physician/	1 □Yes 2 ŽŠNo 9 □ Unknown	9 Unknown								
٠ <u>,</u>	s that ned b	V P	Part II. Other significant conditions	-	ulting in the u	nderlying cause giv	ven in Part I.	23e. Did	tobacco	use contribute to	the cause of d	Jeath?
rds	quires en sig uld be	Completed by	Atrial Fibrilla	tion				_ 1□	Yes 2	2 X No 3 □ P	robably 4 🗆 l	Jnknown
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Division of Vital Records,	lor A after Direc	Certification: To	4 ☐ Homicide determined	building, etc. (Speci.	fy)	eet, lactory, office		City or To	wn, State	te)	Brai Floate Want	ibot,
	spital sours neral		29a. Certifier 1 Certifying Pi	hysician: To the best of my kno	owledge, deal	th occurred at the t	ime, date and pl	ace, and due to th	e cause(s) and manner a	s stated.	
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical		miner: On the basis of examina and manner stated.								s)
	To the To the To the Complex C	Me	29b. Signature and title of certifier	٨		29c. Licens	se number		29d. Da	ate signed (Mont	h, Day, Year)	
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	8		30. Name and address of person who	,	~	Print)		1		1 00017		
			Rosemary Iwunze, 31. Date filed (Month, Day, Year)	MD 8600 Old G		own Koad	, Bethes	sda, Mary	Tanc	2081/		
	Sta Registr		JAN 2 2 2010 🕹	Vacua d.	ak)							
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CROWNOVE, MARION, 1/18/10 9 556 AM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 7:10 Å $_{\rm M}$ Jamuary 24, 2010 Physician/ Loretta Marion Clarke Medical 4a. Facility Name (if not institution, give street and number)
Oak Crest Care Center 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Parkville Baltimore . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) Mary land **Funeral** 87 Days 9/26/1922 1 - M 2 X F 215-14-0309 Hours Director Usual Residence of Decedent 10b.County Baltimore show 10a. State MD Oc. City, Town or Location Parkville 10d. Inside City Limits Examiner must be notified at Director 28a-f 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 8832 Walther Blvd 21234 USA within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 9 þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify Specify: White "natural" 3 Nidowed 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me once. Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname)
Blanche L. Garner 17. Father's Name (First, Middle, Last) John L. Saddler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4916 Missi Lane Fort Mill, SC 29708 Joy Ostroski / Niece Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/22/2010 Hilltop Serv. Corp Towson, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility Towson, Maryland 21204 Ruck Towson Funeral Home, Inc. 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Alzheimers Physician, disease or condition Medical resulting in death) Examiner Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate burial-transit Cause (Disease or linjury that initiated events resulting in death) Last After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-trar Due to (or as a consequence of): Physician/Medical IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Year P.O. Part II. Other significant conditions contributing to death but not resulting In the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hypertensive Cardiovascular Disease, COPD, CHF Records, 2 No 3 Probably 4 Unknown Completed 1 Yes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed 1 Yes 2 No of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's (6 Other: 1 🗌 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify, 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral director. 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Division 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined the Hospital Medical 281 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 34 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 01/21/2010 R171944

State

Registrar

Michealle

31. Date filed (Month, Day, Year)

JAN 2 2 2010

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Q

Books

32. Registrar's Signature

CRNP MSN 8800 Walther Blvd, Parkville.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#10e, perFH, G899, 1/22/2010, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death CAECILIE COHEN Physician/ Month A M 2010 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Hospita of Social Security Number [179-14-7310 7. Age (In yrs. last birthday) If Under 24 Hrs. 8 Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 🗆 M 2 🗓 F Hours Min. Month Day Year) Director **GERMANY** Usual Residence of Decedent or 28a-f show 10a, State 10b County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director MD N/A BALTIMORE 1 Yes 2 □ No 10e. Street and Number **Bland** 10f. Zip Code 10g. Citizen of What Country? and Mental Hygiene. is marked other than "natural", or items 23a Funeral 5915 BALND AVENUE 21215 USA death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. \$ 1 Never Married 2 Married Cohem Cohem Baltimore, Maryland 21215-0036 hours after 1 Yes 2 No If Yes, Give Year or Dates Specify. 3 🗓 Widowed 4 🗆 Divorced Specify: Completed WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 HOMEMAKER OWN HOME Be be filed \ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) SAMUEL **GUNDERSHEIMER** BERTHA SCHWARZSCHILD injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau MIRIAM SHNIDMAN / DAUGHTER 5915 BLAND AVENUE BALTIMORE, MD 21215 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) HAR JEHUDA CEMETERY 01/21/2010 PHILADELPHIA, PA 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Sign, ture > Funeral Service Licens 8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition nset and Death Physician/ Due to () as a consequence of): Medical resulting in death) Examiner mone Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): requires that the death certificate be executed ng physician and as the bunal-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: nse yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) for in the past 12 months? Pregnant at time of death Month Dav Year 1 Yes 2 No 9 Unknown signed by the at d be detached for Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Completed 1 Yes 2 No 3 Probably 4 Unknown plonds 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law After this certificate has autopsy page performed? 1 Yes 2 No Yes 2 No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) RE No ၉ 1 🗌 Yes Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural (Month, Day, Year, 5 Pending injury s after death, Director: Aft 1 Yes 2 No Accident Investigation the 6 Could not be within 24 hours after de To the Funeral Director completed filled in by th Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 2010 E 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MA Date filed (Month, Day, Year) 2. Registrar's Signature State JAN 2 2 2010 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2010 A M Shirley Virginia DeBraccio January 3:00 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Essex 613 Seena Road 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 01/06/1923 1 M 2 X F Months Days Mary Land 87 219–16–2890 Director Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🏝 No Maryland Baltimore Essex 10e Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a c Funeral U.S.A. 305 Worton Road 21221 "natural", or items dical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, o. Black, White, etc. 1 Never Married 2 Married þ 3altimore, Maryland 21215-0036 1 Yes 2X No Specify: 3 X Widowed 4 Divorced White Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked o Lewis Griffin Maqdalena Nagle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lewis DeBraccio (Son) 7421 Rossville Boulevard, Baltimore, Maryland 21237 1 and 2 s of Health item 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. Page 1 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Bayview Crematory, Ind 01/25/2010 Baltimore, Maryland 21. Signature of F 22. Name and Address of Facility Ski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part 1. Epter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ mus cardial infantion Medical Due to (or as a consequence of): Examiner coronery arten Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Directs for as a conscouence of the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Pregnant at time of death 1 Yes 2 2 9 Unknown cate has been signed by the a page 2 should be detached in 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ vasular Disease Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed this certificate has been nie thoraci aneurypim 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Hypertension 2 🗆 No 1 Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☑ Other (Specify Daughter's 2 🔀 No 1 Tyes ျ 1 Inpatient 2 ER/Outpatient 3 IDOA re Hospital or Attending PP in 24 hours after death. The Funeral Director: After the Puneral filled in by the funers 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: iniury 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide within 24 hours after de To the Funeral Directo completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) onall attanasio 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Philadelphia Road

DHMH 17 Rev 7/2009

State Registrar

10-00540	
Keisha Depass	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Keisha Depass		1- For State Registrar	State of	[:] Maryla		-	nent of cate of			Menta	al Hy		Reg. No.	201	0	01267
Physicia Medical Exami	an/	1. Decedent's Name (First, Keisha De	pass								2	Date of Dea Month January 1	Day 19, 20			3. Time of Death 1602 hrs
)		4a. Facility Name (if not in: Union Memorial F		reet and nu	mber)		4	b. City, To Baltimo		ocation of	Death		40	County of None		
Funeral Director		5. Social Security Number 086-72-6222	6. Sex		-	yrs. last bi	irthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24Hrs. Min.	8. Date of B			Foreign	nplace (State or n ntry) NY
any		Usual Residence of Deced			10c	. City, Tow	n or Location	on								10d. Inside City Limits
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vith the Maryland 23a or 28a-f shov	Director	10e. Street and Number 13 Pine Hil	1 C+					10f. Zip C	ode 21163	2			_	zen of Wha ted S		•
h with thems 23a be noti	Funeral [11. Marital Status	1	2. Was Dece		r in U.S.			t of Hispa	anic Origin		cify Yes or No			Americ	an Indian, Black,
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland hand Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f she matic event, the Medical Examiner must be notified at once	y Fun	1 Never Married 2 3 Widowed 4	Divorced If	Yes	2 🗴	No			No.			,		Specify:		ack
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5-0036 led within 72 Hygiene. I other than the Medical	omple			5+	,	Pe	diatr	ic Or						Medic	al	
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D 21 should b and Mer 7 is mar	2	19a. Informant's Name/Rel Amar Thomas										ral Route Nu odstoc			State, 163	
		20a. Method of Disposition 1 Burial 2 XCree				20b. Place	of Disposi atory or oth	tion (Name				Date		Location - C		
Itimore, it. Pages I a ortant: If ite			er Specify:		M01		nt Cr					0/2010				D ily F.H.Inc
Balti permit. Departm Importa injury o	/ 5	(ax)	11				411	2 01d	l Co.	Lumbi	a P	ike Eli	lico	tt Ci	ty,	MD 21043
Physician Moi al		23a, Part I, Enter the disea failure. List only one Immediate Cause (Final di	cause on each	itions that ca line. u1mona					dying, si	uch as car	diac or r	espiratory an	rest, sho	ock, or hear		Approximate Interval Between Onset and Death
Examiner		or condition resulting in de	ath) Due	e to (or as a			o c in o c									
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uted nd ransit	Exar	events resulting in death)		e to (or as a	conseque	nce of):										
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Division of Vital Records, piral no Attending Physician: The law requirers after death. Here this certificate has been sifilled in by the funeral director. Page 2 should the control of t	ertification:	2 Accident 3 Suicide 6 Homicide	Could not be determined	28e. Place (Specify)	e of Injury	- At home,	farm, stree	t, factory, c	office bui	lding, etc.	2	8f. Location (or Town,		nd Number	or Rura	al Route Number, City
Division of Vital Records, P.O. Box 6876(To the Hospital or Attending Physician: The law requires that the death within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the b	dical C	29a Certifier 1 Certify	ing Physician: al Examiner:O	n the basis o	of examina											
To will	Me	29b Signature and title of		id manner st	aled				License O.C.M					_		th, Day, Year)
X.		30 Name and address of p	erson who com	pleted caus	M e of death	(Item 23a))		U.U.IVI				Jail	uary 20,	2010	
X		Russell Alexande		sistant M	ledical E			Penn St	reet, E	Baltimor	e, M D	21201				
St Regist	ate trar	31. Date filed (Month, Day,	2 2 2010		gioriai S S	gratule	par	Kel								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, Amend #5,9,10a-e,11,15,16a-b,17,18,19a-b,20a-c,22, per Itil g899 1/26/10 TT State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 - For State Registrar 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** MONP 13:25 auree anyary 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore tomore 5. Social Security Number unk 6. Sex Medical (enter If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** 1 □ M 2 🖾 F Months Days Hours Yrs 69 July 5, 1940 MA Director 023-30-0301 Usual Residence of Decedent 10a. State unk 10b. County 10d. Inside City Limits 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at unk unk unk vyes 2□No Director MD BAltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code unk 501 W. Franklin St. Funeral USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify white Specify: þ 3 XWidowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) unle 1111to (Give kind of work done during most of working life. DO NOT use retired) of Health and Mental Hygiene, item 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Pharmacy Clerk unk unk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) -unk-Be -1111/c Elizabeth Margaret Cryan Joseph Francis Crowley ပ္ 19b Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
128 Noxon St.
301 St. Paul Place Baltimore, MD 21201 19a Informant's Name/Relationship (Type, Print) **Lisa DeSimone/ Daughter** Mercy Medical Date unk 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition Department of H Important: If ite any injury or ot once. Chesapeake Crematory Re Crematory

22. Name and Address of Facility CAFA/ Stephen D. Johnman, P.A.

By Transport of Stephen D. Baltimore Street 21. Signature of Funeral Service Director 8717 Green Pastures Dr. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest speck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) respirat **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions r any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the hurial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗆 Ectopic pregnancy Month Day 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 Hlnknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by mintesknal Cleedin 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number Name and address of person who completed caus GOR GREENE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 2 2 2010 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 4a. Facility Name (If normstitution, give street and number) January /Medical 20 0106 0007 4b. City, Town, or Location of Death 4c. County of Death Examiner Shad Security Number Grove Adventist 9. Buthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** 1 M 2 DF Months Days Hours Min. Sept., 16 1949 213-56-8902 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Examiner must be notified Director Patoma lontgomery 10e. Street and Number 10g, Citizen of What Country? 2085 Funeral 12005 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: þ 3 ☐ Widowed 4 ☐ Divorced Specify: white Completed event, the Mudical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 19 Accountant Trave 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 other traumatic Frances 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Fin K 2005 Starview C Spouse Potomac MD 20854 auct 2518 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date JUK 20c. Location - City or Town, State Important: If it any injury or o 4 ☐ Donation 5 ☐ Other (Specify) Baltimore xemotoru 21. Signature of Funeral Service Licens 22. Name and Address of Facility IAM 1232 Midvalle 23a. Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Septic Shock disease or condition resulting in death) Minutes /Medical Due to (or as a consequence of): Examiner Preumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed P.O. Box 68760, & Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after deatl Funeral Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 9901 Medical Center Dr

Registrar DHMH 17 Rev 1/2001

State

JAN 2 2 2010

32. Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** JAN. EDWARD DALE EUBERT 20 2010 4:35A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner **HARFORD** UPPER CHESAPEAKE MEDICAL CTR. BEL AIR if Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Min. Months Hours 1**X**XM 2□ F Days MĂRYĹAND 214-30-5374 76 July 2,1933 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County rai", or items 23a or 28a-f show 1 □Yes XX No Funeral Director CHURCHVILLE MARYLAND | HARFORD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21028 2602 Lakeview Ct. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married > Married 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates: Specify: White Completed by timore, Maryland 21215-003 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) President Nursing Home 12 yrs. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) s 1 and 2 should be fi f Health and Mental H item 27 is marked ot Bertha Regina Nickles William Edward Eubert 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2602 Lakeview Ct. Churchville, Md. 21028 19a. Informant's Name/Relationship (Type. Print) Mary C. Eubert (Wife) item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition Pages 1 permit. Pages
Department of
Important; If it
any Injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 1-23-2010 Parkwood Cem.Mausoleum Baltimore, Md. 4 □ Donation 5 □ Other (Specify Entombment 21. Signature of Funeral Service Licensee ^{22.} Lassann Fune<u>ral Home</u> Other 7401 Belair Rd. Baltimore, Md. 21236 Approximate Interval Between Onset and Death 23a, Part 1, Enter the disease. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of) Physician/Medical nding p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 □ Yes 2 □ No Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Was an autopsy performed? page 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28c. Injury at Work? To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 No investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signature and title of certifier 29c. License number

Registrar DHMH 17 Rev 1/2001

State

eTsckarus M.D. 500 Upper Chesapoake (

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month AMERICO ANTHONY FOLCARELLI 7:80 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A GOOD SAMARITIAN HOSPITAL BALTIMORE 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday **Funeral** 1 □ M 2 🔀 Days Hours Min 10871927 82 MĂRYLAND **Director** 218 22 8400 Usual Residence of Decedent 28a-f sho 10a. State 10b. County 10c. City, Town or Location iral", or items 23a or 28a-f sho Examiner must be notified at 10d. Inside City Limits Director MD BALTIMORE WHITE MARSH 1 Tes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6039 LORELEY BEACH ROAD 21162 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 St Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc δ 1 Never Married 2 Married 1 Yes 2 X No Specify: WHITE "natural", Specify: Completed 3 X Widowed 4 ☐ Divorced WWII traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 h and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) FEDERAL GOV'T INDUSTRIAL SPECIALIST Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ REGINALDO FOLCARELLI GUENDALINA PETRILLI 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important if item 27 is any injury or other traunonce. FRANCIS JABLONSKI/ PERRY RIDGE CT ROSEDALE, MARYLAND 21237 13 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 1/22/10 METRO CREMATORY BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CVACH / ROSEDALE FUNERAL HOME Licensee 1211 CHESACO AVE BALTIMORE, MD21237 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Medical Due to (or s a con equence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury Examine and that initiated events resulting in death) Last attending physician a for use as the burial Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) Day Pregnant at time of death signed by the at Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 🗆 Yes 2 📉 No 3 🗆 Probably 4 🗀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2 spital or Attending Physician: The lours after death.

neral Director: After this certificate heliled in by the funeral director, page 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 Tyes 2 No မ 1 Suppatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 \square Pending work 2 Accident
3 Suicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a Hospital Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and on investigation, it may specific a state and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) OIG 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ch Ravo 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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Exam	iiner	Sacred Heart	Street and non	iber)		4b. City, To		7 ille				ounty of Dea ince G		
Funera	al	5. Social Security Number 6. Se		7. Age (In yrs.	. last birthday)	If Under 1	1 Year	If Under	24 Hrs.	8. Date of Birt	h	g. Bir	thplace (State of	or Foreign
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Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at	ouce.	21. Signature of Funeral Service Licens	. ^							shall's				
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tendir	jan/	23b. Was decedent pregnant in the past 12 months?		Birth 2 Fe	etal death 3			у			23	d. Date of de	-	Year
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Division of Vital Recc To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2	Medical	29a. Certifier 1 Certifying Physical Examination only one) 3 Certifying Nursi	ner: On the bas	sis of examinati	ion and/or inves	tigation, in m	ny opinior	n, death oc	curred at	the time, date a	nd place, a	nd due to the	cause(s) and ma	anner stated.
To the within To the	≥	29b. Signature and title of certifier	Se Practioner.	TO the best of t	my knowledge,		License		- and place			signed (Mont		
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A		30. Name and address of person who		· ·			1			MD 000				
\ 	tate	Raman Tuli, MD 31. Date filed (Month, Day, Year)		O Darne	estown ature	Kd. Ga	aith	ersbu	ırg,	MD 208	Lδ			
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2010 7:35p Luis Horacio Fortin January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Maplewood Park Place Bethesda Montgomery 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign . Age (In vrs. last birthday) **Funeral** Argentina 1 DM 2 D F 89 Hours Feb 14, Year) 920 Director 113-40-4897 Usual Residence of Decedent show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location notified at Director 1 🗆 Yes 2 🖳 No 28a-f Bethesda Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be Funeral 20814 United States 9707 Old Georgetown Road #2112 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married þ Yes 2x No 3altimore, Maryland 21215-0036 1 XYes 2 No Specify: If Yes, Give Year or Dates Specify: 'natural", Completed 3 Widowed 4 Divorced Latin White the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. College (1-4 or 5+) **5+** Elementary/Seconday (0-12) Economist International Banking Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည unk unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9707 Old Georgetown Road, #2112 Bethesda, MD 20814 Blanca de Fortin/wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State Final Journey Crematory 1/21/2010 4 Donation 5 Other (Specify) Woodbine, Maryland 21. Sign wre of Funeral Service Licens 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 M00957 Beverly L. Heckrotte, P.A. 23a. Part Lenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 2006 Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Follicular Lymphoma Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical that the death certificate be Box 68760 IF FFMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Coronary Artery Disease 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Multi Infarct Dementia 24a. Was an performed 1 ☐ Yes 2 ☐ No Yes 2 XNo the Hospital or Attending Physician: 25. Was case referred to medical **Division of Vital** B 26. Place of Death (Check only one) examiner? Other: 2 X No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 X Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Registrar

(Check

only one)

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

within 2

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win

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael A. Newman 2021 K Street, NW

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practions of the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Washington, DC 20006

29d. Date signed (Month, Day, Year)

January 20, 2010

29c. License number

DC5496

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Reg. No Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) January 18, 2010ar Physician 6:50 PM Farang Yazhari Foroutan /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Suburban Hospital Bethesda Montgomery 8. Date of Birth (Month, Day, Nov. 19, 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 T 7. Age (In vrs. last birthday) **Funeral** Min. 1 □ M 2 🖺 F Months Days Hours 215-31-4512 Iran 95 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County ed other than "natural", or items 23a or 28a-f show event, the Medical Exeminar must be notified at 1 □Yes 2 No Director Rockville Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number with 20852 United States 6121 Montrose Road Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status hours after 1 Never Married 2 Married If Yes, Give Year or Dates: 1 ☐ Yes 2 K No Specify: Persian þ 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) within 72 (Give kind of work done during most of working life. DO NOT use retired) e filed within 7 cal Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental ! Mousa Yazhari Jaani (unknown) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra 8719 Hempstead Avenue, Bethesda, Maryland 20817 Faezeh Foroutan/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition January 22, 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Parklawn Memorial Park 2010 Rockville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Robert A. Pumphrey Funeral Home/ Chase, Inc. 7557 Wisconsin Ave., Bethesda, Maryland 20814-3501 21. Signature of Funeral Service Licensee 23a. Part 1. Litter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Advanced Dementia Physician /Medical Due to (or as a consequence of): Examiner Unknown Urinary Tract Infection Sequentially list conditions, if any, salaring to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consecuence of: Examine Anemia Unknown that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Unknown Dehydration Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed Was autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 1 □Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🖾 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred or Attending 1 🖺 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 2 Accident To the Funeral Director: completely filled in by the 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital Medical 1 🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only

State

Baltimore, Maryland 21215-0036

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31. Date filed (Month, Day, Year)

Rosemary

Iwunze.

29b. Signature and title of certifier

32. Registrar's Signature

Registrar

29c. License number

eled cause of death (tem 23a (Type, Print)). 8600 Old Georgetown Road, Bethesda, Maryland

D0065720

29d. Date signed (Month, Day, Year)

January 18, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2-RANDISON /Medical 4a. Facility Name (If not institution, give street and number) 4b. City Town, or Location of Death County of Death Examiner altimore andalistown 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days 1 NM 2 □ F Director 213-30-Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f shov item 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, the Medical Examinar must be notified at Director 1 Yes 2 No nna 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? X Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 W Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Completed by Specify. Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retified) filed withir Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important; If item 27 Is marked oth any linjury or other traumatic event <u>once.</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) svandison -32 20b. Place of Disposition (Name of cemetery, crematery or other p 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Deurial 2 ☐ Cremation 3 ☐ Removal from State 25/2010 4 ☐ Donation 5 ☐ Other (Specify) Signature Funeral Service Licensee 22. Name and Address of Facility MD 2120 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause a each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** KEBRAL /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine The law requires that the death certificate be executed physician and the burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical as IF FEMALE use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 🗆 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) signed by the a □Yes o 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has autopsy performed? Yes 2 No page After this certificate 1 ☐ Yes Hospital or Attending Physician; filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Hospital: 2**/2** No 1 ☐ Yes Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 5 Pending Μ within 24 hours after death.

To the Funeral Director: A 2 Accident investigation 1 □Yes 2 🗆 No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Difference of the date and place and place and place, and due to the cause(s) and due to the cause(s 29a. Certifier completely (Check only one) To the and manner stated. 29b. Signature and title of certifier 30. Name and address of person who death (Item 23a) (Type, Print) State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 5:41 AM 2010 January 17, Thomas Brooks Goon /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Upper Chesapeake Hospital Bel Air Harford If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 XM 2 1 F Director 1964 Apr 11, Maryland 218-92-5144 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla. Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Madical Examinar must be rediffied at once. Director 1 ☐ Yes 2 No Baldwin Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 21013 United States 6507 Lewis Road 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐Yes 25No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: þ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Law Firm 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas Goon Helen Timmons 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kimberly Goon /Sister in Law 820 Tilghmon Drive Bel Air, MD 21015 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Jan 20 Beltsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 2010 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MO1442 Cremation and Funeral Alternatives 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final nellmama **Physician** disease or condition resulting in death) /Medical Du to (or as consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (v) as a consequence of) sician and burial-transit Due to (or as a consequence of) Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Live birth 2 Fetal death 3 Ectopic pregnancy Month Year Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) signed by the a ☐Yes 2☐No 9 I Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s this certificate 1 ☐Yes 2 ☐ No 2 Z No 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 12 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 100 Natural 5 Pending 1 □Yes 2 □No investigation 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation in my opinion, death accurred at the time. 29a. Certifier Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2010 100 63220 GEORGE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

Year)

ORIGINAL

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend #26, per M D G899 1/22/10 TT
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 16, IDA LITTLE GREENE JANUARY 2010 10:50 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cecil Pear Tree Manor Assisted Living Colora Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Min. Months Days Hours 1 □ M 2 1 F Director 218-05-6277 90 4, 1919 Maryland Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show ortant: If item 27 Is marked other than "natural", or Items 23a or 28a-f shov injury or other traumatic event, I'm Nedical Exyralism must be a colfficed at 1 ☐ Yes 2 No Director Maryland Harford Darlington 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1730 Castleton Road 21034 **USA** Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. should be filed within 72 hours after 1 Never Married 2 Married 1 □Yes 2 XNo aryland 21215-0036 Specify. Specify. δ 3 Nidowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Engineering Technician 8 U.S. Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ith and Mental h Be ပ Adalbert (nmn) Latka Valeria (nmn) Osika 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 Health a 1730 Castleton Road, Darlington, MD 21034 Stanley G. Little Sr. Son altimore, Department of Heal 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Francis de Sales 1-21-10 Abingdon, Maryland permit. 21. Signatur Funeral Service Lie 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final arkinson Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Physician; The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No for Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Dlnknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate 1 □ Yes 2) 1 ☐ Yes director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Assisted Living Other: 4 Nursing Home 5 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 5 Pending investigation 1 Natural 1 ☐Yes 2 ☐No 2 Accident 24 hours after deatl Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Limit Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one and manner stated To the I 29d. Date signed (Month, Day, Year) 29b. Signature 005 8

State Registrar

Orla 31. Date filed (Month, Day,

Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Re

102501

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month JANUARI Day EDWARD HOLMES Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner JOHNS HOALING BAYVIEW MEDICIAL CEPTE Baltimor Social Security Number 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral 1** ★ M 2 □ F Months Days Hours Min 11/11/1917 Pennsylvania **Director** 157-03-4775 Usual Residence of Decedent 28a-f shov 10a. State 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director 1 Yes XX No Maryland Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1015 Maple Road 21221 U.S.A. 12. Was Decedent Ever in U.S.
Armed Forces?

XXYes 2 □ No 1944- Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, or Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 X No Specify: Specify: Completed 1946 3XXWidowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 6 Trucking Driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ Katharine Potter Edward Holmes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health Robin Hutson (Daughter) 1015 Maple Road, Baltimore, Maryland 21221 other 1 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Department of H Important: If ite any injury or ot cemetery, crematory or other place, 1 Burial AX Cremation 3 Removal from State 4 Donation 5 Other (Specify) Bayview Crematory, Inc. 01/23/2010 Baltimore, Maryland Signature of Fun ral Service Licensee 22. Name and Address of Facility Old Eastern Avenue, Essex, Maryland 21221 1407 Ther the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Tem ase or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Exami the attending physician and hed for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) To Be Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Year Day Pregnant at time of death 2 No certificate has been signed by the irector, page 2 should be detached Unknown 9 Unknown P.0. Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 🗌 Yes 2 🗆 No Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No funeral director, 26. Place of Death (Check only one) Hospita Other: 1 Inpatient 2 ER/Outpatient 3 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Director: After (Month, Day, Year) 1 Matural Pending 1 Yes 2 No 2 Accident completed filled in by the Investigation 3 Suicide
4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

Hospital 24 hours within 2

> State Registrar

Medical

29a. Certifier

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BADAMAS

DHMH 17 Rev 7/2009

1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

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AVENUE

29d. Date signed (Month, Day, Year)

Baltimere

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month HALE ONSTANCE 20:0 18:15 M JANUARY Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMERY PARK WASHINGTON ADVENTIST HOSPITAL **IAKOMA** If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 424–36–4843 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) 123/1926 1 M 2X Director GA Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a, State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10c. City, Town or Location 10d. Inside City Limits Director MD Prince George's Hyattsville 1 🗌 Yes 2 🗐 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3572 Dean Drive Apt 02 20782 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 Yes 2 No Specify Specify: 3 Widowed 4 Divorced Completed Black the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ed other than 'e event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Government <u>Social Worker</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental H 27 is marked of traumatic ever မ Martha Johnson Elbert Stallworth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3572 Dean Dr. Apt. 02 Hyattsville, MD 20782 permit. Page 1 and 2: Department of Health Important: If item 27 any injury or other transmore. Barry Hale, son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 1/22/2010 Beltsville, MD 21. Signatury of Funeral Service 22. Name and Address of Facility Rapp Funeral & Cremation Svcs. 933 Gist Ave. Silver Spring, MD 20910 23a. Part 1. Enter the disease, or complications that caused the death. Co not enter the shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Pnysician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to himselfate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine burial-transit Hospital or Attending Physician; The law requires that the death certificate be executed and Due to (or as a consequence of): attending physician I for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Live Birth 2 Fetal death Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death detached ģ Part II. Other significan 23e. Did tobacco use contribute to the cause of death? sate has been signed page 2 should be de Completed by 4 Unknown 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 Tes 2 🗌 No 25. Was case referra Be 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) (Specify) 2 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Matural 5 \square Pending work? 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No М Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the only one) 29b. Signature and title of certifie 29d. Date siggled (Month, Day, Year)

Registrar

7701 CARROLL AVE

20912

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D

DHMH 17 Rev 1/2001 OCME 2006 OCME

ORIGINAL

OCWE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 2:38 P M Charles George Hartjen Jänuary Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner **Baltimore** 4024 Forest Val<u>ley Road</u> Baltimore Birthplace (State or Foreign Country)
 Germany 8. Date of Birth (Month, Day, Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 1 🗓 M 2 🗆 F Days Hours Months Director 119-01-3689 88 October Usual Residence of Decedent "natural", or items 23a or 28a-f shov edical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🙀 No Baltimore Baltimore Marvland | 10f. Zip Code 10g. Citizen of What Country? Funeral 21234 U.S.A. 4024 Forest Valley Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No permit. Page 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or i any injury or other traumatic event, the Medical Examin once. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 x No Specify: Specify: 3 Widowed 4 Divorced Completed White Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Suffolk County Inspector Police Department Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ **Hellwig** Ε. Hartien George 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Monkton, Maryland 619 Pinev Hill Road Charles A. Hartjen Son 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Hilltop Service Corp 1-21-2010 Towson Maryland Se lice Lice 22. Name and Address of Facility Ruck Towson Funeral Home, Towson, Maryland 21204 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 4k disease or condition resulting in death) oranaw Medical Medical Examiner ue to (or as a consequence of) Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence ot): To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav 5 Other (specify) Pregnant at time of death ☐ Yes ☐ ☐ Unknown 9 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 1 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Yes 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 28d. Describe how injury occurred Certificate: 24 hours after death. Funeral Director: After Natural 5 Pending 2 🗌 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) title of certifier 29b. Signa 29d, Date signed (Month, Day, Year) 29c. License number and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Schilling

32. Registrar's Si

2103

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) January 201°0 18 **Physician** 10:55 p M Betty Herron W. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Towson Edenwald If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Months 1 □ M 2 🗓 F 84 Washington DC 578-26-5945 May 26, 1925 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location death with the Maryland 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examirer must be rottlied at 1 ☐ Yes 2 🔀 No Baltimore Towson Md. Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21286 800 Southerly Rd #531 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 □ Yes 2X No Specify: 9 White 3 X Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) U.S. Government Analyst 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Julie Louise Travis John H. Williams, Sr. ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 18812 Fox Chase Ct. Parkton, Md. 21120 Ms. Helen Rowe/ Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 1-21-10 Washington DC Rock Creek Cemetery 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Son Funeral Home, Inc. 21. Signature of Juneral Service Licens 1050 York Rd. Towson, Md. 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on-cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Hypoxemia Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Preunonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Advanced chronic obstructive pulmonery disease attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE Division of Vital Records, P.O. Box 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 🗷 No 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) s been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Congestive heart failure 2 No 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t page 2 s autopsy performed certificate | 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medica Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death After t 5 ☐ Pending investigation 1 Natural 2 Accident within 24 hours after common to the Funeral Director; A' 1 □Yes 2 □No 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide ō 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. BUCKNP 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Jan. 18, 2010 Aschen CRNP R154032 30. Fame and addre s of person who completed cause of death (Item 23a) (Type, Print) 800 Southerly Rd Towson, MD 21286 Susan Scherr CRNP 32. Registra's Sign 31. Date filed (Month, Day, Year) State JAN 2 2 2010 Registrar

MIG TONYA JOHNS 10-00366 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unk Unk State of Maryland / Department of Health and Mental Hygiene 1. For State Certificate of Death Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day January 13, 2010 0010 hrs **Medical Examiner** Mia Tanya Johns 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Bon Secours Hospital ICU Baltimore NA If Under 1 Year | If Under 24Hrs. | 8. Date of Birth(MM/DD/YYYY) | 9. Birthplace (State or 5. Social Security Number 6 Sex 7. Age (In yrs, last birthday) **Funeral** oreign Months Davs Hours Director 11-08-64 MD 214-84-3658 1 M 2 X F 45 Country) Yrs Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once. 1 Yes 2 No MD Baltimore Catonsville Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21 Elderberry Court 21228 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. 14. Race - American Indian, Black, White, etc. African If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces 1 X Never Married 2 Yes 3 Widowed 1 Yes 2 X No specify: Divorced If Yes, Give Year Specify: American ۾ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Nursing Home 12th Grade NA Nurses Aide 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Hannah L. Chavis David J. Johns 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1202 Dorchester Avenue Baltimore, MD <u>Sandy Chavis-Aunt</u> 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 1 X Kurial 2 Cremation 3 Removal from State Mt. Zion Cem. 01-23-10 Lansdowne, MD 4 Donation 5 Other Specify. 22. Name and Address of Facility Wylie Funeral Home 638 N. Gilmor Street Baltimore, 21. Signature of Funeral Service MD 2121 23a. Part I, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Medical Death a. Meningitis Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last the attending physician and ned for use as the burial - transit sician/Medical UNPENDED AMENDED The law requires that the death certificate be Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Live birth Fetal death 3 Ectopic pregnancy Month Day Year Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 ✔ Unknown Unknown Part II. Other significant conditions 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I ۾ 1 Yes 2 No 3 Probably 4 V Unknown Chronic alcohol abuse Completed After this certificate has been 24a, Was an 24b Were autopsy findings available prior to completion of cause of autopsy death? performed? page ✓ Yes 2 No 1 🗸 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death. 25. Was case referred to medical 26.Place of Death (Check only one) uneral director, Be Hospital: 1 Inpatient Other Nursing Home 5 Residence 6 Other ER/Outpatient 3 DOA ဥ 1 Yes 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 V Natural 1 Yes 2 No Pending To the Funeral Director: completely filled in by the 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) determined 4 Homicide 29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. **Medical** 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c License number 29d. Date signed (Month, Day, Year) O.C.M.E. January 13, 2010

State Registrar 31. Date filed (Month, Day, Year)

JAN 2 2 2010

ORIGINAL

30. Name and address of person who completed cause of death (Item 23a)

Pamela E. Southall, MD Assistant Medical Examiner

OCME

111 Penn Street, Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 45 AM 2010 anuary /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Wa dge wood Mohonia 001 If Under 24 Hrs. If Under 1 Year 5. Social Security Number 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday 6. Sex **Funeral** Low Yrs. Months Days Hours Min. 1 M 2 M 2 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Experience must be notified at 1 Nes 2 No -daewoo Funeral Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 2104 Mononia Pages 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 6 14 Race - American Indian. 11. Marital Status 1 Never Married 2 Married altimore, Maryland 21215-0036 1 □Yes 2 🕠 🗝 0 Specify: Blace If Yes, Give Completed by 3 Widowed 4 Divorced Year or Dates: 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be if Health and Mental I 2 Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Royte Number, City or Town, State, Zip Code) Wai rrol one 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Department of H Important: If ite any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State or 4 Donation 5 Dother (Specify) den 21. Signature of Funeral Service Licensee timbre, Wil 10 23d. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to or as a conseque ce of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed burial-tra P.O. Box 68760, physician Physician/Medical as the attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ♠ No 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy Year Month Day 5 ☐ Other (specify) ned by the a 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by page 2 should be 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certificate has been completely filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 2 No 1 ☐ Yes 1 □Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ■ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar

DHMH 17 Rev 1/2001

State

30. Name and address

31. Date filed (Month, Day,

Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deat Physician/ Month 2 Year 11866 MCKSON Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death ANINE ARUNDEL Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Country) **Funeral** Months (Month, Day **Director** Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Director 1 ¥ Yes 2 ☐ No 10g, Citizen of What Country? Completed by Funeral USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify If Yes Give 3 Widowed 4 Divorced Specify: Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) မ 19a. Informant's ame/Relationship (Type, Print) HURNOVER 20a. Method of Disposition 20b. Place of Disposition (Name of or other place Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Signature of Juneral Service Licens 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated so or lingury Due to (or as a consequence or). s been signed by the attending physician and should be detached for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3

Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an the Funeral Director; After this certificate has I page 2 performed 2 1 No 2 [1 Tes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at Natural 5 Pending work?
1 Yes 2 No death. 2 Accident
3 Suicide
4 Homicide Investigation completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 24 only one) 3 [29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 055596 01/13/

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

tel jo Huy Cles Busse Md 2100

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Dav Year JURKOV 10:07 A /Medical January 2010 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner The Johns Baltimore Hopkins Bayview Hospita If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 11-05-1943 Birthplace (State or Foreign Country)
____ **Funeral** Months Days Min. 1 □ M 2 🔯 F Hours 66 Director 218-42-8122 MD Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Exeminer must be notified at Director 1 ☐ Yes 2 No MD Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 'natural", or items 23a 7911 St. Gregory Drive 21222 USA Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian. Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Important in the Important in Elementary/Secondary (0-12) College (1-4or 5+) Caregiver Self Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas Jurkovitz, Sr. Lena Fiore 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7911 St. Gregory Drive Dundalk, MD 21222 Paul M. Jurkovitz (Brother) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 01-25-2010 Bayview Crematory Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home of BelAir a. Inc 610 W. MacPhail Rd Bel Air, MD 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ASCUD **Physician** YEARS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed P.O. Box 68760. siclan and burial-tran Due to (or as a consequence of): Physician/Medical phys the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav 4 Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ∐Yes 2 XNo 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 □ No Medical Certification: To 1 ☐ Inpatient 2 XER/Outpatient 3 ☐ DOA filled in by the funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Division 5 Pending investigation Injury 1 MNatural To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only one)

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

29c. License number

10028684

29d. Date signed (Month, Dav. Year)

and manner stated.

MB

32. Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michealle G. Harrison Cent BOO Walther Blyd, Packville MO 2/234 State 31. Date filed (Month, Day, Year) 32. Registral Signature	305	n 24 h	Med														nanner stated.
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michealle G. Harrison CENP 9900 Walther Blyd, Parkville Mo 2/234 State 31. Date filed (Month, Day, Year) 32. Registra Signature	X	Vithi To th	Γ	29b. Signature and title	of certifier	7							29d. Da	ate signed (M	lonth, D	ay, Year)	
Michealle G. Harrison CRNP 8000 Walther Blyd, Packville MO 2/234 State 31. Date filed (Month, Day, Year) 32. Registra Signature	10			► Muchea	lle Set					1944	<u> </u>		1/19	1/20/0			
State 31. Date filed (Month, Day, Year) 32. Registra & Signature		•		30. Name and address	of person who	ompleted cause of de	eath (Item 23)	a) (Type, P 7) 110	rint) Blu	d,	Packul	le Mo	2/2	234			
				31. Date filed (Month, D	lay, Year)	32. Registra	Signature	A	back	,			•	,			

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	State of Maryland /	Department of He	alth and Me	ntal Hygiene

2010 0120		
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2010 0128	7	ſ

Barbara L ee Johnst	ton State of Maryland / Department of h 1- For State Certificate of L Registrar		2010 0128
Physician/ Medical Examiner	Decedent's Name (First, Middle,Last)	2. Date of Do Month January	eath 3. Time of Death 12, 2010 1104 hrs
	4a. Facility Name (if not institution, give street and number) 4b.	. City, Town, or Location of Death Rockville	4c. County of Death Montgomery
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 213-44-6438 1 M 2XF 64 Yrs.	Martha Davis Davis Little	Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) MD
re Maryland or 28a-f show any fied at once,	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location MD Montgomery Rockville 10e. Street and Number 10c. City Town or Location Rockville 10e. Street and Number 10e. Stre	10f. Zip Code	10d. Inside City Limits 1 Yes 2 No 10g. Citizen of What Country?
th the Maryland 23a or 28a-f sh notified at once		20851	USA
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyggene. Important: If item 37 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	3 Widowed 4 Divorced If Yes, Give Year or Dates:	Decedent of Hispanic Origin? (Specify Yes or I , specify Cuban, Mexican, Puerto Rican, etc.) 'es 2 X No specify:	White, etc. Specify: White
5-0036 ed within 72 hours yygiene. other than "natu the Medical Exan Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Attorn	*	16b. Kind of Business/Industry
Baltimore, MD 21215-0036 bernit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygene. Important: If item 27 is marked other than nijury or other traumatic event, the Medica To Be Comple	Charles Norton Johnston	18.Mother's Name (First, Middle Dorothy Irene	Folker
MD 27 d 2 should th and Me n 27 is ma numatic continuatic continuatic	Kathleen J. Tevnan, sister 9515 B	Address (Street and Number or Rural Route N Bruce Dr. Silver Sprin	ng, MD 20901
nore, ages l and off Heal off: If iten	20a. Method of Disposition 1 Burial 2 XXCremation 3 Removal from State 20b. Place of Disposition crematory or other		20c. Location - City or Town, State
Baltin permit. P Departme Importar	21 Service Licensee M01539 22. Nan	ne and Address of FacilityRapp Funer B Gist Ave. Silver Spr	al & Cremation Svcs.
Physician Nedical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):		arrest, shock, or heart Approximate Interval Between Onset and Death
	or condition resulting in death) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Vascular aneurysm Due to (or as a consequence of):		
be executed cician and inial - transit dical Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Coulomb as a consequence of the country of t	lerotic cardiovascula	r disease
	X UNPENDED AMENDED PI line a-c, 27.	per ME G900 2/17/10	TT
). Box 68760 the death certificate by the attending physiched for use as the buphysician/Me	past 12 months?	death 3 Ectopic pregnancy r (Specify)	23d. Date of delivery Month Day Year
, P.O. B res that the d signed by the detached d by Phy	Part II. Other significant conditions contributing to death but not resulting in the und		tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown
cords aw requi		per 1 ✓ Yes	is an opsy formed? 24b. Were autopsy findings available prior to completion of cause of death? 1 Ves 2 No
F Vital Rec Physician: The ar this certificate ral director, page To Be Com	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3	26.Place of Death (Check only one) 3 DOA Other Nursing Home 5	Residence 6 🗸 Other: Scene
ion of Vitending Physicath. tor: After the funeral	27. Manner of Death 1 X Natural 5 Pending 2 Accident Investigation 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury (Month, Day, Year)	ury 28c. Injury at Work? 28d. Describ	e how injury occurred
Division of spiral or Attending nours after death. Tilled in by the funer of the fu	3 Suicide 6 Could not be determined (Specify)	factory, office building, etc. 28f. Location or Town,	(Street and Number or Rural Route Number, City , State)
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the Medical Certification	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred one) 2 Medical Examiner: On the basis of examination and/or investigation and manner stated.	n, in my opinion, death occurred at the time, dat	
N N	29b. Signature and title of certifier	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) January 13, 2010
	· ·	Penn Street, Baltimore, MD 21201	
State Registrar	31. Date filed (Month, Day, Year), 2 2 2032 Registra's Signature	parl	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Month Year Physician/ Stanley Edward Jackson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Hospice Towson Baltimore If Unde 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number Age (In yrs. last birthday) 8. Date of Birth **Funeral** Sept 3, Year Hours Washington DC Days Min. 1 🕅 M 2 🗆 F T918 91 Director 578-62-0692 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD 1 Yes 2 □ No **Baltimore** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 1 East University Parkway #703 21218 USA 12. Was Decedent Ever in U.S. Armed Forces?

1X Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify. Specify: black. 3 Widowed 4 Divorced 42-51 Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ 12 education educator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Eugene Edward Jackson Inez Christine Booth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 410 U Street NW Washington, DC Lauretta Jackson/sister in law 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4
☐ Other (Specify) Signature of Euneral Service Licensee stare and attention bard 655 W. Baltimore Street 21201 MD Baltimore, 23a. Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardlac or respiratory arrest speck, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) ess Medical Due to (or as a or nsequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IE FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death n signed by the a ld be detached fo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed director, page 2 should certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed? Yes 2 X No 2 🗆 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA After this completed filled in by the funeral 27. Manner of Death

1 X Natural
2 Accident 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: 5 Pending work' 1 Yes 2 No Investigation 24 hours after deatle Funeral Director: 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one 29b. Signat nd title of certifier icense number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

JAN 22

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2010

		1 - For State Registrar		Ce	rtificate of	Death		Reg. ۱۸	lo.	
		1. Decedent's Name (First, Middle,	Last)				2. Date of D		Day Year	3. Time of Death
Physicia /Medic		Arlene	Kelly				01	11	2010	11:30 P
Examin		4a. Facility Name (If not institution,	give street and number)		4b. City, Town, o	r Location of Dea	th	4	c. County of Dea	th
		Potomac Valley N			Rockvil:				Montgome	
uneral		,	Sex 7. Age (In yrs		Months Days	If Under 24 Hrs Hours Min	. (Month, D	ay, Yea	9. Bir	thplace (State or Foreig ountry)
ctor		238-86-9230 Usual Residence of Decedent		66 Yrs.			08/05	/194	.3	NC
		10a. State 10b. County	10c. C	ity, Town or L	ocation					10d. Inside City Limits
	ţō	MD Prince	George's U	oper Ma	arlboro					ty⊠Yes 2 □ No
Ì	Director	10e. Street and Number	000180		10f. Zip Code	-		10g. (Citizen ol What C	ountry?
	al D	10805 Sutton Dr.			20775			US	Α	
	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of H	lispanic Origin? (S	Specify Yes or N		14. Race - Ame Black, Whi	
		1 Never Married 2 Marrie			1 ☐ Yes 2 № No		to rilouri, oto.,			
l	d by	3 Widowed 4 Divorced	Year or Dates:		12100 2210				DI	Lack
l	Completed	15. Decedent's (Specify only highest	Education grade completed)	16a. Dece (Give	edent's Usual Occup e kind of work done DO NOT use retired	ation during most of wo	orking	16b.	Kind of Business	/Industry
	dm	Elementary/Secondary (0-12)	College (1-4or 5+)			3)				
l		11th 17. Father's Name (First, Middle, La	ect)	Cı	ıstodian	19 Mother's Na	me (First, Middl	o Maid	Healthc	are
	Be		(31)					e, iviaiui	en sumanne)	
l	٥	Norman Kelly 19a. Informant's Name/Relationship	(Type Print)	10h Mail	ing Address (Street		e Lucas	har Cit	v or Tourn State	Zia Codel
					-					
		Cathy Jenkins/Da 20a. Method of Disposition	~	Place of Disp	Spring Acosition (Name of	1	Date		Location - City or	
		1 Burial 2 ☐ Cremation 3	Removal from State	cemetery, cre	ematory or other place				•	
		4 ☐ Donation 5 ☐ Other (Special Signature of Fundamin Signature of Fundamin Signature of Fundamin Signature of Signature	and a	nilton	Burial Go 2. Name and Addre	in. 01/.	16/2010 archall	Wi g F	lson, NC	
		VID m	24 Ahall	1						iome
		23a. Part. Enter the disease, or co	omplications that caused the dea		4217 9th S		-		20011	Approximate
		shock, or heart lailure. List or Immediate Cause (Final	nly one cause on each line.			19, 00011 00 00.00	o or roop natory	arrost		Interval Between Onset and Death
		disease or condition resulting in death)	a. Severe I		la					years
			Due to (or as a conse	quence ot):						
	er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conse	quence ol):						
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	V .							
	Еха	resulting in death) Last	Due to (or as a conse	quence ol):						
	cai	,	d							
	Medicai									
1		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fel		□Ectopic pregnancy	,			23d. Date of de	
	Physician/	in the past 12 months? 1 ☐ Yes 2 🏝 No	4 Pregnant at time of		Other (specify)				Month	Day Year
	hy	9 🗆 Unknown								
	by F	Part II. Other significant condition	s contributing to death but not re	sulting in the	underlying cause giv	en in Part I.	23e. Did	tobacci	o use contribute t	o the cause of death?
l							1] Yes	2 X No 3 □ P	robably 4 Unknow
ı	Completed						24a. Wa	s an opsy	24b. Were a	utopsy lindings available completion of cause of
ı	Хот						per 1 🗌 Yes	formed?	death?	
l	Be (25. Was case referred to medical examiner?				26. Place of De	ath Check only			
l	2	1 ☐ Yes 2 🗷 No	Hospital: 1 ☐ Inpatient 2 [☐ ER/Outpatie	ent 3 DOA Oth	er: 4 🛛 Nursing I	Home 5 🗆 Res	sidence	6 □Other (Spe	ecify)
		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of	ol 28c. Injur Wor	y at k?	28d. Describe	how in	jury occurred	
l	atic	2 Accident investiga	tion	,,		Yes 2 ☐ No				
l	Certification:	3 Suicide 6 Could no 4 Homicide determin		home, farm, st	treet, lactory, office		28f. Location City or To	(Street	and Number or R	ural Route Number,
l	Cer		3,,							
	edical	29a Certifier 1 Certifying (Check only 2 Medical E)	Physiciam To the best of my kr caminer: On the basis of examin	uwladge, dea	th occurred at the te	ne, date and plac	e, and due to the	e date a	(a) and mailtier a	e to the cause(s)
l	Med	one)	and manner stated.							
	Σ	29b. Signature and title of certifier	<u> </u>	0	29c. Licens				Date signed (Mon	**
		Hne	veller	Plt 1	4D D3826	52		Ja	nuary 13	2010
		30. Name an address of person w	no completed cause of death (Ite	m 23a) (Type	Print)	och A.	of 33	a all	wille.	4) 2085T
		ANURITA M	ENDHIRATTA	1 240	of Keska	iun Bl	VD, K	y CK	W11,1	20805
ta tr		31. Date filed (Month, Day, Year) -	2010 Servers	nature.	1					
stra	şi .	JAN 22	2010 perus	p. 19	Parke					
1/20	101									/

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 10-00553 State of Maryland / Department of Health and Mental Hygiene Daren Fitzgerald Klosterman Certificate of Death 1- For State Reg. No. Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day January 19, 2010 2300 hrs DAREN FITZGERALD KLOSTERMAN **Medical Examiner** 4b. City, Town, or Location of Death c. County of Death 4a. Facility Name (if not institution, give street and number) Montgomery 107 Whites Ferry Road @ Morrow Road Poolesville 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign If Under 1 Year If Under 24Hrs. 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Country) Months Days Min Hours Director 1XX M 46 NOV.30, 1963 CEDAR RAPIDS, IA 2 F 483.92.5304 Usual Residence of Decedent 10d. Inside City Limits any 10c. City, Town or Location 1 XX Yes 2 No or 28a-f show LINN CEDAR RAPIDS ΙA Baltimore, MD 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "matural", or items 23s or 28s-f sht
Important: If item 27 is marked other han "matural", or items 23s or 28s-f sht Director 10g. Citizen of What Country 10e. Street and Number 10f. Zip Code 277 21st AVE. S.W. 52404 USA Funeral 13 Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces' 1 Never Married 2 XX Married 2XX No Yes Yes 2 XX No specify: Specify: WHITE 3 Widowed Divorced Yes, Give Yea ≥ 16a. Decedent's Usual Occupation (Give kind of work done 6b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) PROJECT SUPERINTENDANT CONSTRUCTION 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be WILLIAM L. KLOSTERMAN VIRGINIA HARRIS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 277 21st AVE. S.W., CEDAR RAPIDS, IA 52404 KATHY KLOSTERMAN 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date crematory or other place) 1 XX Burial 2 Cremation 3 XX Removal from State Jan 25, 2010 CEDAR MEMORIAL CEMETERY CEDAR RAPIDS. 1A Donation 5 Other Specific 22. Name and Address of Facility FINK FUNERAL HOME, P.A. GLEN BURNLE GRE CORY M01148 426 CRAIN HWY lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Enter the dise Physician tween Onset and failure. List only one cause of each line Wedical Death a. Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last signed by the attending physician and be detached for use as the burial - transit Physician/Medical UNPENDED AMENDED Records, P.O. Box 68760 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Day Live birth Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Yes 2 ✓ No 3 Probably 4 Unknown ģ Completed page 2 should 24b. Were autopsy findings available 24a. Was an has been prior to completion of cause of autopsy performed? death? 1 🗸 Yes 2 No ✓ Yes 2 No certificate 26.Place of Death (Check only one) director, the Hospital or Attending Physiclan; 25. Was case referred to medical of Vital æ Other₄ examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 ✓ Other: Scene this 1 Yes 2 No 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? After 27 Manner of Death Operator of motorcycle in collision Certification Jan 19, 2010 2249 hrs Division Natural Yes 2 V No Pending the Director 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) 107 Whites Ferry Road @ Morrow Road, Poolesville, Md determined (Specify) Major Road / Highway 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier O.C.M.E. January 20, 2010 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Ana Rubio MD. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar JANZZ

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			For State Registrar	Otate of it	narytaria	Certifica				Reg. N	2010	01292
			Decedent's Name (First, Middle, Last)					2. Date Mont	of Death		3. Time of Death
	Physici /Medic		Edward J. Kenny						Ö I		3 20%	2237 PM
	Examin		4a. Facility Name (If not institution, give			1	, Town, or	Location of		4	lc. County of Dea	ith
			Sinai Hospital 5. Social Security Number 6. Se				er 1 Year	If Under	24 Hrs & Date	of Birth	O Bi	dhalana (State or Foreign
	Funeral Director			X 2 M 2□F	Age (In yrs. lasi 84	Yrs. Months		Hours		of Birth h, Day, Yea		rthplace (State or Foreign
			Usual Residence of Decedent					1	reb	9, 19	25 New	York
)	within 72 hours after death with the Maryland ane. than "natural", or items 23a or 28e-f show ite Marical Examities f. ust be multified at	Ļ	10a. State 10b. County MD		Balti	Town or Location						10d. Inside City Limits 1√2 Yes 2 □ No
Z	ath with the Marylan 23a or 28e-f show ust be notified at	Funeral Director			Daill		in Codo			100.0	Citizen of What C	11
B	with ti	OL.	10e. Street and Number 524 N. Charles St	root #11	1 Ω		ip Code 21201			log. c	USA	outility :
3	ter death w Items 23a	era	11. Marital Status	12. Was Deceder				ispanic Ori	igin? (Specify Yes n, Puerto Rican, et	or No-	14. Race - Am	
1 9	or iter	Fun	1 Never Married 2 Married	1 XYes 2[□No	1□ Vos		ın, Mexicar Specify:		C.)	Black, Whi	
nny, Edwan 215-0036	ural',	Completed by	3 ☐ Widowed 4 M Divorced	Year or Date	s: ' 45–46							
) - 5-	"nati	lete	15. Decedent's Ed (Specify only highest grad	de completed)		16a. Decedent's Us (Give kind of w life. DO NOT	ual Occup: rork done d use retired	ation <i>during m</i> os 1)	st of working	16b.	Kind of Business	s/Industry
12	withir iene. than	шо	Elementary/Secondary (0-12)	College (1-4d	or 5+)	admini					social s	security
7	be filed that Hygie of other lead other lead other leads	BeC	17. Father's Name (First, Middle, Last)						er's Name (First, M			
S:		To B	Edward J. Kenny					Anı	ne M. But	1er		
β	2 should and Mer Is marke aumatic		19a. Informant's Name/Relationship (7		1	19b. Mailing Addre				-		Zip Code)
(-	is 1 and 2 should of Health and Meritem 27 Is marke other traumatic		John Kenny/nephe	:W	20h Plac	e of Disposition (N		au G	lencove,		Location - City o	r Town. State
Known altimore, 1	00		1 ☐ Burial 2 ☐ Cremation 3 ☐		com	etery, crematory or	other plac	ce)		200.	accusion only o	
万萬			'4 ☑ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licen			22. Name	and Addres	ss of Facili	ity	i:		
Ba	permit. Departr Imports any inju		Romald S.		rector	State	Ana Imore	tomy • MD	Board 65.	5 W. H	3altimor	e Street
			23a. Parti. Enter the disease, or companies shock, or heart failure. List only	lications that caus	sed the death.					tory arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	2		SWD						Onset and Death
	/Medical Examiner		resulting in death)	Due to (or	as a conseque	nce of):						
	LXGITIIICI	J.	Sequentially list conditions,	b. Due to (or	as a conseque	nce of):						
	uted I Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	_ = = (=	, , , , , , , , , , , , , , , , , , , ,	,						
o,	exection and and rial-tra		resulting in death) Last	Due to (or	as a conseque	nce of):						
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Box 68	artifica ling ph e as t	Physician/Medi	IF FEMALE:	20. 11								
B ₀	ath ca attend for us	lan/	23b. Was decedent pregnant in the past 12 months?		ne of pregnand 2 □ Fetal de tat time of deat	eath 3 Ectopic		/			23d. Date of d Month	Day Year
P.O.	the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknowi		(ii 3 0 0 (iiei (3pecily)			06.00		
مَ ا	s that ned b	by Pł	Part II. Other significant conditions of	ontributing to deat	h but not resulti	ing in the underlying	g cause giv	en in Part	I. 23e	. Did tobacc	o use contribute	to the cause of death?
rds	equire en sig ould b									1 🗆 Yes	2 □ No 3 □ F	Probably 4 Unknown
ဝင္	law re as be 2 sho	Completed							24a	Was an autopsy	prior to	autopsy findings available completion of cause of
= E	The cate h	Con							10	performed Yes 2	No death?	
Vita	ician certific	Be	25. Was case referred to medical examiner?	Hospital:		_	Oth	105	e of Death (Check		- 50	
of	Phys r this aral dii	To it	1 ves 2 No 27. Manner of Death	1 ☐ Inp 28a. Date of I (Month,		R/Outpatient 3 180. Time of	28c. Injur Wor	4 🗆 14	ursing Home 5 28d. Des		njury occurred	респу)
ion	nding ath. r: Afte e fune	ation	1 Natural 5 ☐ Pending 2 ☐ Accident investigation		Day Year)	Injury M		rk? Yes 2 □]No			
Division of Vital Records,	r Atta	Certification;	3 Suicide 6 Could not be determined	200. Flace 01	Injury - At hom etc. (Specify)	e, farm, street, fact	ory, office		28f. Loca City	tion (Street or Town, St	and Number or l	Rural Route Number,
Di	ital or irs aft rel Di											
	Hosp 24 hou Fune stely fi	edical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exan		s of examinatio	edge, death occurre n and/or investigati						
_	To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Med	29b. Signature and title of certifier			2	29c. Licens	se number		29d.	Date signed (Mo	nth, Day, Year)
	F > F 0							69		O	1/15/	2010
_			30. Name and address of person who		of death (Item 2				ls. Park	11.	Mn	21286
			31. Date filed (Month, Day, Year)	ay ay	istrar's Signatu		m l	W & O O	. Take	MILE	. 1 1	212-1
	St Regist	ate rar	JAN 2 2 2010		Jan a Gigitatu	had s						
				L. Mary Land	U 0.	AND COLUMN						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND TTEM# 1 perphys#17,18,19a, perph, 6899,1722/2010, ws

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2010 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Michael 2. Date of Death 3. Time of Death Kukelyansky JANUARY 2010 18 7:05 Дм KUKELANSKY MICHAEL 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death GILCHRIST HOSPICE CARE TOWSON BALTIMORE 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 6. Sex 1 Ϊ M 2 ☐ F Country) UKRAINE Days Months Hours Min. 067/299 F950 59 213-25-9448 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 Yes 2 X No BALTIMORE REISTERSTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21136 12404 PRESERVE WAY 12. Was Decedent Ever in U.S. Armed Forces**?** 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced WHITE Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry during most of working (Specify only highest grade completed) (Give kind of work done (life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) QUALITY CONTROL OFFICER STRUCTURAL ENGINEERING 18. Mother's Name (First, Middle, Maiden Surname) Budilovsky 17. Father's Name (First, Middle, Last) **Kukelyansky KUKELANSKY AARON KUKELANSKY** ELKA 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Five. Print) 12404 PRESERVE WAY, REISTERSTOWN, MD 21136 ZHANNA KUKELÁNSKY 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State REISTERSTOWN, MD 4 Donation 5 Other (Specify) BALTIMORE HEBREW 1/19/2010 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death hapabocellular Immediate Cause (Final montres disease or condition resulting in death) rhosis epahins Due to (or as a consequence of) ves, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregna

5 Other (specify) 23d. Date of deliven Ectopic pregnancy Year

Physician Medical Examiner

injury or other

Department of H Important: If ite any injury or otl

Physician/

Medical

10a. State

MD

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Funeral

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Completed

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Examiner

Funeral

Director

or items 23a or 28a-f show

traumatic event, the Medical Examiner must be notified at

"natural",

Hygiene.

and Mental Fisher is marked o

t. Page 1 and 2 should be fill thent of Health and Mental tant: If item 27 is marked or

permit.

law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

been signed by the attending physician a should be detached for use as the burial-

ieral Director: After this certificate has filled in by the funeral director, page 2 s

s after death

within 24 hours a To the Funeral D

Be Completed by

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Certificate:

Medical

filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 1 ☐ Yes 2 ☐ 9 ☐ Unknown

9 Unknown

Month Dav

23e. Did tobacco use contribute to the cause of death?

1 🗌 Yes 24a. Was an

autopsy

4 Nursing Home 5 Residence 6 Other (Specify) Was put

28d. Describe how injury occurred

MO

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

26. Place of Death (Check only one)

No	3 Probably	4 🗆 Unknown
24b.	Were autopsy fin prior to completic	

25. Was case referred to medical examiner? 2 No 1 Tes

Hospital: 28a. Date of injury (Month, Day, Year)

Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at work? 28b. Time of

performed? death? 1 Yes 2 No

Manner of Death 1 Natural 5 Pending Accident 6 Could not be Suicide

Investigation

1 Yes 2 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29b. Signature and title of certifier

4 - Homicide

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year) 8 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

determined

(HACUSS M) evoles 6701

State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature JAN 22 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 01294 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year 0452M Letts 21 ernon 10 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Maryland Hospital Raltimore University Maryland OF If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Months Days Hours 1**X** M 2 □ F ^{ntry)} Maryland 8,1934 October 212-30-8024 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Perry Hall Balto. 1 ☐ Yes 2 ☑ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21128 9405 Snyder Lane Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black, White, etc. Armed Polices:

12 Yes 2 No
If Yes, Give
Year or Dates: 1956-1960 1 Never Married 2 Married White 1 □Yes 2 □WNo Specify. Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Tavern <u>Tavern Owner</u> 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Laura M. Abbey Harold W. Letts 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9405 Snyder Lane Perry Hall, Md. 21128 Spouse Patricia Letts 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1-25-2010 Parkville, Md. 4 ☐ Donation 5 ☐ Other (Specify) Parkwood 22. Name and Address of Facility Schimunek Funeral Home 21. Signature of Funeral Service Licensee Memmen Williamore Nottingham, Md 21236 9705 Belair Rd. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final neoplasm oneyear malignant disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

Physician /Medical Examiner

Examiner

Physician/Medical

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Completed

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Certification: To

Medical

Department of Health a Important: If item 27 is any injury or other trau once.

Physician

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28a-f show

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items 23a

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Pages 1 and 2 should be

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Funeral

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Completed

traumatic event, the Medical Examiner must be notified at

death with the Maryland

filed within 72 hours after i Hyglene.

Baltimore, Maryland 21215-0036

law requires that the death certificate be executed physician and the burial-trans Box 68760. attending p for use as P.O. I signed by the a Division of Vital Records, Physician: The

or Attending

page 2 s certificate After th funeral To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: At completely filled in by the fu death.

IF FEMALE:

24a. Was an autopsy

performed

1 🗆 Yes 2 📮

24b. Were autopsy findings available prior to completion of cause of death? 2 🗆 No

25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier

fany

29c, License number 18165

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Morton 22 South Greene St. Baltimore, MD

State Registrar

32. Registrar's Signature 31. Date filed (Month, Day, Year) JAN 2 2 2010

1041

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Lennard Lee 4c. County of Death Facility Name (if not institution, give street and number Town, or Location of Death 8. Date of Birth (Month, Day, Yea Aug 11, yrs. last birthday) 9. Birthplace (State or Foreign Min. 1 🕅 M 2 🗆 F Months Hours Country) Mary Land 218-32-7967 Usual Residence of Decedent 10b. County 10c, City, Town or Location 10d. Inside City Limits Baltimore 1 ¥ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6000 Bellona Avenue 21212 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11 Marital Status Armed Forces? Black, White, etc. 1 X Never Married 2 Married Specify: black 1 ☐ Yes 2 💢 No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) unk custodian healthcare 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Grace Cecelia Murdock Arthur Joseph Lee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 428 N. Patterson Park Avenue Baltimore, MD 21231 Bilal Muhammad/nephew 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☑ Other (Specify) in State ce Licensee 3 Name and Address of Facility Board 655 W. Baltimore Street Baltimore, MD 21201

Ph sician/ Medical Examiner

Examine

Be Completed by Physician/Medical

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Certificate:

Medical

29a. Certifier

(Check

only one 29b, Signa

31. Date filed (Month, Day, Year)

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Physician/

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permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a common any injury or other traumatic event, the Madical Conce.

Hospital or Attending Physician: The law requires that the death certificate be executed P.O. Records, Division of Vital

shock, or heart fallure. List only one Immediate Cause (Final disease or condition	ations that caused the death. Do not enter the mode of dying, such as cardiac cause on each line. Full Physics Ventricular	or respiratory arrest, BIOCK	Approximate Interval Between Onset and Death									
resulting in death) Sequentially list conditions, b.	Due to (gras a consequence of): Houte Coronary Sym	1hr										
if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events	c. Due to (or as ylconsequence of): Due to (or as a consequence of): Due to (or as a consequence of):											
resulting in death) Last	Hypertension		V									
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	c. If yes, outcome of pregnancy 1		23d. Date of delivery Month Day Year									
Part II. Other significant conditions control	ributing to death but not resulting in the underlying cause given in Part I.		o use contribute to the cause of death? 2 No 3 Probably 4 Unknown									
Chronic All	philation cocholism	24a. Was an autopsy performed?										
25. Was case referred to medical	26. Place of Death (Chec	ck only one)										
1 LI Yes 2 XINO		ome 5 Residence	6 Other (Specify)									
27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury / (Month, Day, Year) 28b. Time of injury 28b. Time of work? M 1 1 Yes 2 No	28d. Describe how inj	ury occurred									
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)									

1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar ed cause of death (Item 23a) (Type, Print)

e

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Jan. 2010 Physician/ 10, 2:40 PM Μ. Lane Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Southern Maryland Hospital Clinton Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) **Funeral** Feb. 16 Days Hours Year) 1927 1 □ M 2 🛛 F West Virginia 235-40-0115 82 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 Yes 2X No Prince George's Clinton Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20735 U.S.A. 11304 Glissade Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 X Widowed 4 ☐ Divorced White Year or Dates. 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) TV & Appliance 10 Business Woman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Russell Ouickle Luceil Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 20735 1304 Glissade Dr., Clinton, Stephen M. Lane (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 K Burial Cremation 3 Removal from State 1 - 16 - 10Hinkleville, WV Mt. Olive Cemetery 4 Donation 5 Other (Specify) Name and Address of Facility ling—St. Clair Funeral Home S. Kanawha St., Buckhannon ture of Funeral Service License Buckhannon, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Immediate Cause (Final On taid Death Physician/ disease or condition Medical resulting in death) Dué to (or as a Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 Other (specify) Pregnant at time of death completed filled in by the funeral director, page 2 should be detached 1 ☐ Yes ∠ ∟ 9 ☐ Unknown 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Certificate: To Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed has 2 N/ 1 Yes 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 1 🗌 Yes 2 🗹 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 1 Natural 5 Pending 2 No 1 Tyes 2 Accident Investigation Suicide 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Box 68760 P.O. Division of Vital Records, hours after death within 24 hours a

> State Registrar

Medical

29a Certifier

(Check only one) 29b. Signature and title of certifier

determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

🗜 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 26 per doc 2899 1-22-10 vt State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 0^{Month} 1 Day Physician/ 9:09 A M Lowry 2010 Varcer Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard Postwick Road Ellicot City 9890 If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🗷 M 2 □ F Mar 27 Hours Min. 87 North Carolina 244-20-8636 1922 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Director 1 Yes 2 X No Berlin MD Worcester 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral U.S.A. 21811 7 Royal Oaks Drive 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Deceud... Armed Forces? 11 Marital Status Black, White, etc. 1X Yes 2 No
If Yes, Give WW II ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: White 3 X Widowed 4 Divorced Completed 16a, Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Auto Insurance Sales Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ೭ Hatcher Sallie Edmond Lowry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 9890 Postwick Rd., Ellicott City, MD Alexa J. Doxzen-daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Dulaney Valley 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 Cremation 3 Removal from State 1/18/10 Timonium, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee William G. 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Dau 1050 York Rd., Towson, MD 21204 23a. Part 1. Enter the disease, or complications that cause, the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each in ... Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate Due to (or as a consequence of) Exami Cause (Disease or linjury sbeen signed by the attending physician and should be detached for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be-24 hours after death. Funeral Director: After this certificate has been signed by the attending physicis P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ 2 No 3 Probably 4 Unknown 1 🗌 Yes Division of Vital Records, Completed certificate has been irector, page 2 should 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed 1 🗌 Yes 2 🗌 No Yes funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) daughter's Other: 2. No ျ 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation within 24 hours after death

To the Funeral Director: completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Decrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10710 Charter Columbia Dr. 21044 Knight 6020

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 01298 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death TAMOARY Physician/ 2 Y991 121 Ø4: ØØA M Sally H. Lemmon Medical 4a. Facility Name (if not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Examiner Joseph Medical Center OWSON Saint If Under 1 Year I If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Country) Maryland 1 DM 2 D Days Hours Min. Nov. 4. 1924 Yrs **Director** 212-20-1671 Usual Residence of Decedent or 28a-f shov 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Examiner must be notified at **Funeral Director** 1 🗌 Yes 2 🙀 No Towson MD Baltimore 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a 21204 USA 8430 Charles Valley Court 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. "natural", or ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced Completed Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Nursing Registered_Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Charles S. Hammett Rose Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17041 Wesley Chapel Road; Monkton, MD 21111 Patricia Lauer daughter 20a. Method of Disposition

1 ☑ Burial A☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1/23/10 Cathedral Cem. Baltimore, MD 21. Signature of Funeral Service Lic 22. Name and Address of Facility 1050 York Road Inc. Towson, MD 21204 Ruck Towson Funeral Home, 23a. Part 1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ RESPIRATORY FAILURE disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** DAYS LACTIC ACIDOSIS Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to (or as a do reequence of DAYS Hospital or Attending Physician: The law requires that the death certificate be executed HEPATIC FAILURE Due to (or as a consequence of): resulting in death) Last physician a the burial-t Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by RENAL FAILURE 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 2 X No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No မ 1 Natient 2 ☐ ER/Outpatient 3 ☐ DOA Director: After this in by the funeral dir 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide 5 Pending 1 🗌 Yes 2 🗌 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and in of certifier 2010 D39858 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 7601

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32. Registrar's fignatur

OSLER DRIVE

TOWSON, MARYLAND 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ 2010 JANUARY LITVYAK 5:34A M MARIYA Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** N/A BALTIMORE SINAI HOSPITAL 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number Funeral Country) UKRAINE 1 □ M 2 🛛 F 3^M8th 1⁹2⁴ 85 **Director** 220-35-7969 Usual Residence of Decedent show 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b, County Director 1 🛚 Yes 2 🗌 No BALTIMORE MDN/A 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Numbe Funeral 21215 USA 6101 PARK HEIGHTS AVENUE, #2A Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces

1 ☐ Yes 2 ☐ No Black, White, etc. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 1 No Specify: If Yes, Give Specify: 3 🗌 Widowed 4 🗆 Divorced WHITE Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) COSMETOLOGIST COSMETOLOGY Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ MACHKOVSKY LIZA UNKNOWN ARKADY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ARON LITUÝAK / HUSBAND 6101 PARK HEIGHTS AVENUE, #2A, BALTIMORE, MD 21215 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a, Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) BALTIMORE HEBREW 1/21/2010 REISTERSTOWN, MD of Funeral Service icenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, Approximate shock, or heart failure. List only one cau Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or a a Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying and I-transit Cause (Disease or linjury that initiated events resulting in death) Last burial-t cate has been signed by the attending physician page 2 should be detached for use as the burial Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 L. returns.
Pregnant at time of death in the past 12 months?

1 Yes 2 No Month Year Day a 🗌 Unknown g 🔲 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 1 🗌 Yes 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate | 1 ☐ Yes 2 ☐ No Yes 2 completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \(\triangle \) Nursing Home \(5 \) Residence \(6 \) Other (Specify) 2 No 2 ER/Outpatient 3 DOA မ 1 Inpatient within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death 1 ☑ Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 5 Pending 1 ☐ Yes 2 ☑ No Accident
Suicide
Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21208 31. Date filed (Month, Day, Year) 32. Registrar's Ignature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ 4:08 RM 19, 2010 January Harold Loyd Murphy Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Center for Hospice Care Baltimore Towson 5. Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1**X** M 2 □ F Months Hours Min. May 28, 1930 79 Country) Arkansas 557-38-0113 Director Usual Residence of Decedent : If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 21211 United States 1108 W. 38th Street Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces 7 Completed by 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: nd Mental Hygiene. marked other than "natural", White 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Transportation Truck Driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Lilly Myrtle Hendricks John Henry Murphy of Health and Nitem 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joanne Murphy /Wife 1108 W. 38th Street Baltimore, MD 21211 Baftimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Jan 20 Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State permit. Page Department Beltsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 2010 22. Name and Address of Facility
Cremation and Funeral Alternatives 21. Signatiqre of Funeral Service Licensee 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure, List only one cause on each line Immediate Cause (Final schemic Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner anoithnon tell ykeltroug Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) the attending physician and hed for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Pregnant at time of death Yes 2 No 1 L Yes 2 L 9 D Unknown 9 Unknown ate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy perform 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 2 🕅 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation after death Director: Suicide
Homicide Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 29b. Signature 29c. License number 20 2010

Registrar
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State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar Signature

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Wilma L. McGee JOONALL Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 0 5100 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 XF Months Hours Min. 7-24-1937 SHITTY) 72 **Director** 213-32-7265 Usual Residence of Decedent ıral", or items 23a or 28a-f shov Examiner must be notified at 10b. County 10d. Inside City Limits 10a, State 10c, City, Town or Location death with the Maryland Director Harford Havre de Grace MD 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21078 129 Tidewater Dr. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates Specify: White "natural" 3 Widowed 4 A Divorced Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Service Representative Cable Television Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 2008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Julia Musick John Lawson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judith A. McBee - Daughter MD 21227 5206 Talbot Pl., Arbutus, Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🗌 Burial 2 🛛 Cremation 3 🗌 Removal from State 1-21-10 Baltimore, MD Bayview Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bradley-Ashton Funeral Home 21222 2134 Willow Spring Road, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Obstructive Physician/ Chroni disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) attending physician and for use as the burial-transit requires that the death certificate be executed unwartion that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical ピラee, WilmaL上 Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Day Month Year Pregnant at time of death 1 Yes 2 L the page 2 should be detached Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law autopsy 2 1 No 1 🗌 Yes Yes the funeral director. Be 25. Was case referred to medical 26. Place of Death Check only one) Hospital Other: 2 3 No. ၉ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Man or of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending 1 🗌 Yes 2 Accident
3 Suicide
4 Homicide Accident Investigation 2 No 6 Could not be To the Hospital or Atte within 24 hours after de To the Funeral Directo completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1464

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Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day 2010 Year วกั 6:26 Mary Martha McGarvey Jan Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Hospice Baltimore County Towson 8. Date of Birth (Month, Day, Ye Feb. 15, 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days , 1<u>920</u> 1 M 2 X F Months Hours Min. Yrs Director 219-01-3379 Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No Maryland Baltimore County Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2525 Pot Spring Road 21093 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 Married If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify. White 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) filed within 72 Elementary/Seconday (0-12) College (1-4 or 5+) 12 N/AHome Maker Own Home permit. Page 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bartholomew Unsoeld Regina Shepp 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Douglas F. McGarvey (son) 3702 Duddington Way Phoenix, Maryland 21131 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) n. 21, 2010 Jan Evans Funeral Chapel 4 ☐ Donation 5 ☐ Other (Specify) Forest Hill, Maryland 22. Name and Address of Facility
Peaceful Alternatives Funeral & Cremation Ctr., P.A

Cocceptation Ctr Øeffrey L. Gair Timonium, Maryland 23a. Part T. En er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between clint Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or initiary Examine Due to (or as a consequence of) that initiated events Due to (or as a consequence of): resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be ex Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 X No Month Day Year 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown myelom peen Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy certificate 2 🗆 No 1 Yes Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 No ၉ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) WOSDUO After this Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending in 24 hours area con he Funeral Director: Af 1 Yes 2 No Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 To the i 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature a title of certifier 29d. Date signed (Month, Day, Year) 20,2010 Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 TONSUN HANOV CHAMBS 6 701

State Registrar 32. Reg

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Marylar	•			Mental Hy	giene	010	01303	3		
			Registrar 1. Decedent's Name (First, Middle, Las)	t)	Cer	tificate of L	Jeath	2. Date of De	Reg. No	010	3. Time of Death			
	Physicia Medic		HAE KYUNG MCLEA	N AKA H	ELEN Mc			JÄNUAR	Y 15	2 01 0	9:02 P M			
	Examin	er	4a. Facility Name (if not institution, give NATIONAL INSTIT		ш	4b. City, Town, o BETHES	r Location of Dea	th		4c. County of Death MONTGOMERY				
	Funeral		5. Social Security Number 6. Se	7. Age (In yrs.		If Under 1 Year	If Under 24 Hrs		th	9. Birthplace (State or				
	Director		210-74-2330	□ M 2 E F 51	Yrs.	Months Days	Hours Min	July 4,	³ 1958	1 188	rea	_		
	ind show at	5	Usual Residence of Decedent 10a. State 10b. County	10c. Ci	1	10d. Inside City Limits								
	Maryla 8a-f s tiffied	Director	D.C.	,	Washing	ton					1 ₺ Yes 2 □ No)		
	h the had a or 2 be no		10e. Street and Number 4701 Davenport	Street N W	•	10f. Zip Code 20016	-		9	of What Cour	•			
	ath with	Funeral	11. Marital Status	12. Was Decedent Ever in U.	S 13 V	Vas Decedent of H		Specify Yes or No-		ed Stat		_		
320	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	1	Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates.	If	Yes, specify Cuba	an, Mexican, Puer	rto Rican, etc.)		Black, White,				
2-0030	hour "natur dical	plete	15. Decedent's Ed (Specify only highest gra	ducation		ent's Usual Occup		orkina	16b. Kind	d of Business Industry				
	thin 72 sne. than '	Completed	Elementary/Seconday (0-12)	College (1-4 or 5+) 5+	life. Do	NOT use retired)		n n g	U.S.	Govern	nment			
D	led will Hygie other ent, th	Be (17. Father's Name (First, Middle, Last)		11000	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		ame (First, Middle,		name)		_		
yland	d be fi Mental arked rtic ev	욘	Soo Young Oh				Jung	g Shim K	im					
Man	d 2 should alth and I alth and I alth and I are traume		19a. Informant's Name/Relationship (Type, Print) Christopher A. McLean/Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zipe 4701 Davenport St., N.W. Washington, D.C.											
baltimore,	e 1 an t of He lfiten or oth		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Popularion 5 Other (Specific) Norbeck Memorial Park 20b. Place of Disposition (Name of cemetery, crematory or other place) Norbeck Memorial Park 20c. Location - City or To cemetery, crematory or other place) Norbeck Memorial Park											
	it. Pag intmen intant: injury		4 Donation 5 Other (Specify) Norbeck Memorial Park 2010 Olney, Mar 21. Signature of Funeral Serice Licensee M00198 Norbeck Memorial Park 2010 Olney, Mar Robert A. Pumphrey Funeral Home/ 7557 Wisconsin Ave., Bethesda, Marylands											
ga	perm Depa Impo any i	-	21. Signature of Funeral Service Licens	M001	98 PS	bert A. 57 Wiscon	Pumphre nsin Ave	y Funera , Bethes	l Home da, Ma	rylafib	ase 20814-3501			
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only or	olications that caused the dea ne cause on each line.	ith. Do not ente	er the mode of dyir	ig, such as cardia	ac or respiratory ar	rest,		Approximate Interval Between Onset and Death			
	Ph_sician/ Medical	S 8	Immediate Cause (Final disease or condition resulting in death)	a. Fungal Pn						- 1	2 weeks			
	Examiner			Bronchiol		literans	Syndron	ne			1 year			
	_ =	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to for as a consec										
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Š X	th cert ttendii	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregn	tal death 3 🗌	Ectopic pregnan	су		23d	d. Date of deliver	delivery Day Year			
. Box	ne dea / the a ched f	nysic	1 ☐ Yes 2 🔼 No 9 ☐ Unknown	Yes 2 A No 4 Pregnant at time of death 5 Other (specify)										
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¥	n: The ficate or, pag		25. Was case referred to medical			26. D	lace of Death (Ch	1 X Yes	2 No	1 Yes	2 X No	_		
<u> </u>	ysicia is certi directo	To Be	avaminar?	Hospital: 1 🔀 Inpatient 2 🗆	BR/Outpatier	Oth	er:	Home 5 Resi	dence 6 🗆	Other (Specifi	<i>(</i>)			
0	ng Ph fter thi		27. Manner of Death 1 X Natural 5 □ Pending	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Inju	y at </td <td>28d. Describe</td> <td></td> <td></td> <td></td> <td></td>	28d. Describe						
Sion	ttendi death stor: A / the fu	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be		nome farm stre		Yes 2 ☐ No	28f Location A	Street and No	umher or Rura	I Route Number,	_		
Division of Vital Records,	al or A s after il Direction by		4 ☐ Homicide determined	building, etc. (Special		201, 140101), 011100		City or Tou		imber of Hard	Thouse Hambon,			
N	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical		sician: To the best of my know								ed		
	o the inthin 2 or the o	ž	only one) 3 Certifying Nurs 29b. Signature and title of certifier	se Practioner: To the best of n	ny knowledge, d	death occurred at the 29c. Licens		place, and due to the		id manner as st igned <i>(Month</i> ,		_		
	F > F 0		· one			D694	43 Mary	yland		ARY 15				
			30. Name and address of person who o		m 23a) (Type, F	rint)								
	- 01		JANICE M. LE 31. Date filed (Month, Day, Year)		ature 🌶		ER DRIV	E, BETHES	SDA, M	<u>ARYLAN</u>	D 20892			
	Stat Registra		JAN 2 2 2010	32. Registrar's Sig	park									

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** P^{M} 17, 2010 9:25 Marvin F. Merrill, III January /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Sykesville
If Under 1 Year | If Under 24 Hrs. | Copper Ridge

5. Social Security Number Carroll 6. Sex 1Å M 2□ F 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Yrs Director 004-42-2263 67 March 23. 1942 Massachusetts Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits in than "natural", or items 23a or 28a-f show the Medical Exercitive must be notified at 1 ☐ Yes 2X No Director Maryland Montgomery Rockville the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with 20853 14313 Barkwood Drive United States Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊡ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: ₽ S 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7:
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "in any injury or other traumatic event, the Mediance. Elementary/Secondary (0-12) College (1-4or 5+) President Benefit Management Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Marvin Francis Merrill, II Fernande Breton 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Ann Merrill / Wife 14313 Barkwood Drive, Rockville, Maryland 20853 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State January 4 □ Donation 5 □ Other (Specify) 2010 Norbeck Memorial Park Olney, Maryland 22. Name and Address of Facility
Robert A. Pumphrey Funeral Home/Rockville, Inc
300 West Montgomery Avenue, Rockville, Maryland 20850-2805 21. Signature of Funeral Service Licensee M01360 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** End Stage Dementia Years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) requires that the death certificate be executed burial-tran Due to (or as a consequence of): Box 68760, physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy for 1 in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) □Yes 2□No o the detached 9 Unknown 9 Unknown ٦. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 2X No 3 Probably 4 Unknown Diabetes, Hypertension 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an law page 2 s autopsy performe 2 No 1 ☐ Yes director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4X Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Tes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After or Attending 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after dead n by the 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide filled Hospital 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) the within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year) 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bonnie S. Dank CRNP, Copper Ridge, 710 Obrect Road, Sykesville, Maryland 21784

R100599

January 19, 2010

State of Maryland / Department of Health and Mental Hygiene, For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** 0135 13 M 4b. City, Town, or Lo 4a. Facility Name (If not institution, give street and number) ai 19 2010 /Medical Town, or Location of Death 4c. County of Death **Examiner** Under 24 Hrs. Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday **Funeral** 1 M 2 □ F Hours Min. 56 242.90.6150 Aug 31, 195B **Director** Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heath and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It we fixed at a contract to other traumatic event, It we fixed at 11 Yes 2 □ No Funeral Director MD Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 21229 31 N. Ellamont Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☑ No Black, White, etc Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Specify: Specify: Completed by 3 Widowed 4 Divorced Black 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Liquor Store 10 Stock 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unk Unk ဂ္ Sonny 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 31 N. Ellamont St. Baltimore, MD 21229 Sheri Pullen /Fiancee 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Jan 20, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Beltsville, Maryland 4 Donation 5 ☐ Other (Specify) 2010 Chesapeake Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Cremation and Funeral Alternatives ▶ 8717 Green Pastures Drive Towson Maryland 21286 Approximate Interval Between Onset and Death 23a. Part 1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Cance 9 MONTH -lend / /Medical Due to (or as a consequence of): Examiner neumonio Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Box 68760. nding physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year signed by the aid 5 Other (specify) 1 ☐ Yes 2 ☐ No P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 🖺 No 1 ☐ Yes 1 Tyes Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this Certification: To 27. Manner of Death 1 ☑ Natural within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral 28b. Time of 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation (Month, Day, Year) 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Karaker Boltimore, 5 GREEN& SV 32. Re 31 Date filed (Month State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For
State
Registrar Certificate of Death Reg. No. 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month () Physician/ 20 20Î0 Pallay 10:45 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Mount Airy 2508 Braddock Road If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Min 1 🗆 M 2 💢 F 1722/1919 Hungary 220-38-7200 Director 90 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits at Director notified Mount Airy 1 Yes 2 No 28a-f MD Carroll 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code "natural", or items 23a o Funeral 21771 2508 Braddock Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Force Black, White, etc permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or in any injury or other traumatic event, the Medical Examin ones. 1 Never Married 2 Married ģ 2 X No Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 K No Specify: If Yes, Give Specify: 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Home Owner Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname)
Maria Dominyak 17. Father's Name (First, Middle, Last) 2 George Andrasik 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2508 Braddock Road, Mount Airy, MD 21771 Bela Pallay Jr. / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 1/23/2010 Parkville, MD Parkwood Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MD 21204 Towson, amyn Ruck Towson Funeral Home, Inc. 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ oastric disease or condition resulting in death) Medical Examiner Sequentially list conditions Examiner if any, leading to immediate
Cause (Disease or iinjury Due to (or as a consequence of) ending physician and use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No for Month Day Year 1 Yes 2 9 Unknown been signed by the serviced should be detached ned by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy perform Yes 2 No 1 Yes 2 No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 X No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 27. Manner of Death 28b. Time of 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred Certificate: Natural injury 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined City or Town, State) within 24 hours a To the Funeral D 1 🖒 crtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signa 29d. Date signed (Month, Day, Year)

Registrar

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death - Month Physician/ 3:50 PM 2010 Januar Kenneth Michael Ouinn 20 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4h City Town or Location of Death Examiner Union Memorial Hospital Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days (Month, Day, Year) 1 XM 2 - F Hours Country) Maryland Director 216-88-4677 48 Usual Residence of Decedent 28a-f shov 10b. County 10d. Inside City Limits 10a. State 10c. City. Town or Location filed within 72 hours after death with the Maryland Director iral", or items 23a or 28a-f s Examiner must be notified 1 X Yes 2 No Baltimore Maryland 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21218 USA 3034 Guilford Avenue, Apt. 12 Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces Black, White, etc. 1 Yes 2 X No "natural", or 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. Specify: 3 Widowed 4 Divorced White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than " Elementary/Seconday (0-12) College (1-4 or 5+) Customer Service Representative Banking 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thelma Nancy Bonds Roland Richard Quinn Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 615 Connelly Road, Rising Sun, Maryland, 21911 Thelma Quinn / Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State injury or Baltimore, Maryland Gardens of Faith Cem: 1/25/2010 4 Donation 5 Other (Specify) at the A Funeral Service & Consee 22. Name and Address of Facility McComas Funeral Home, P.A. J. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ Preumonia disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate Due to (or as a consequence of) He Cause (Disease or iinjury attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical The law requires that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Other (specify) Pregnant at time of death signed by the a 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy performed? Yes 2 No this certificate 1 Yes 2 No or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) eral Director: After th filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury Natural 5 Pending after death. Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a To the Funeral C To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioners To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 43894 20,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD th. Dav. Year 32. Regis State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #2, per DVR 8899 1/20/10 TT Translate of Maryland Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death żoĭo Ö7 Physician/ Month 0 725 ARTER Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Harwood Mandrin House If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) 6. Sex Funeral 1 **Z** M 2 □ F Months Days Hours Min. Sept 14 Year 1933 WasWington DC Yrs 76 Director 577-46-1624 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 🗆 Yes 2 🔀 No MD Anne Arundel West River 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 20778 USA 1011 Back Bay Beach Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. "natural", or 1 X Yes 2 No If Yes, Give Year or Dates. þ 1 Never Married 2 X Married within 72 hours after Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify. Specify Completed 3 Widowed 4 Divorced 153-57 permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) federal government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ John Wise Ruefly Helen Mae Lowry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth Ruefly/spouse 1011 Back Bay Beach Road West River, MD 20778 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 🖾 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Live State and Address of Facility Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ pesserie disease or condition resulting in death) Medical Due to (as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): attending physician and for use as the burial-transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery Box 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Year Pregnant at time of death 1 Yes 2 9 Unknown been signed by the should be detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Hospital or Attending Physician: The law requires Records, Completed Were autopsy findings available prior to completion of cause of 24a. Was an has autonsy performed? Yes 2 No death? this certificate 1 Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital Other: 1 Yes 2. No 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer 1 Natural injury work? 5 Pending Accident Investigation 3 Suicide
4 Homicide 8 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number Name and address of person who completed cause of death (Item 23a) (Type, Print) NNAPOLIS KENTA MO 441 HIGHWAY 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) January 2010 **Physician** 9:56 a M Jacquelyn G. Russo /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner n/a Baltimore Keswick 9. Birthplace (State or Foreign Country)
Maryland If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept 30 1923 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months 1 □ M 2 💢 F 218-14-0320 Sept 86 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County show at 1 ☐ Yes 2 ☑ No r 28a-f sh notified a Director Baldwin Md. Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If them 27 is marked other than ".... any injury or other traumant." p o ns 23a c must be USA 21013 4300 Sweet Air Rd. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Was Decedent of Hispanic Origin? (Specity Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 □ Yes 2 X No If Yes, Give 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify: White If Yes, Give Year or Dates: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Antique Antique Dealer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mildred McCambridge Mary Thomas Gray မှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Stevenson, Md. 21153 PO Box 348 Mr. Frank Russo, Jr./ Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 1-20-10 Hydes, Md. 4 ☐ Donation 5 ☐ Other (Specify) St. John Hydes 22. Name and Address of Facility RUCK TOWSOn Funeral Home, 1050 York Rd. Towson, Md. 21. Signature of Funeral Serice Ligensee 23a. Part1. Exfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Acute OVA SCIX disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Advonied Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner maestin Due to (or as a consequence of). Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No Live birth 2 Fetal death 3 Ectopic pregnancy Month Year Day 4□Pregnant at time of death 9□Unknown 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 ☐ Unknown Be Completed 24a. Was an autopsy performed 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1∏ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 1 Yes 2 No 1 Inpatient Medical Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 ☑ Natural 5 Pending investigation 1 Tyes 2 No 2 ☐ Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division or Vital Records, P.O. Box 68760,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W MA 1600 31. Date filed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

29a. Certifier (Check only one)

29b. Signature and

title of coxtifier

29d. Date signed (Month, Day, Year)

MT. ROYAL AUE, BALTIMORE 21217

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 2010 5:30 A M Physician/ January Catherine Marie Roddy Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner Baltimore** Towson Arden Courts Assisted Living 9. Birthplace (State or Foreign 6. Sex 1 \(\text{M} \) 2 \(\frac{1}{X} \) F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number **Funeral** (Month, Day, Year) Jarch 13. Maryland Months Days Hours Min. Yrs March Director 219-01**-**5108 Usual Residence of Decedent 10d. Inside City Limits or 28a-f show should be filed within 72 moves and Mental Hygiene.

I is marked other than "natural", or items 23a or 28a-f show it marked other than "natural" or items 25a or 28a-f show it marked other the Medical Examiner must be notified at 10c. City, Town or Location 10a. State Director 1 🗌 Yes 2 🙀 No Lutherville **Baltimore** Maryland 10g. Citizen of What Country? Funeral U.S.A. 21093 136 Dublin Drive 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. Black White, etc. Armed Force 1 Never Married 2 Married ģ 1 Yes 2 YNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: If Yes, Give Year or Dates Specify: 3 ▼ Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Emergency Communication 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Baltimore County 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) ပ Lillian Kellv V. Hogan Albert other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Towson, Maryland 1 and 2 s of Health a item 27 606 Meadowridge Road Kevin M. Roddy 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date ■ Burial 2 □ Cremation 3 □ Removal from State Department of Important: If it any injury or o 1-25-2010 Towson Maryland Donation 5 Other (Specify) Mt. Maria Cemetery 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Signature of Funeral Service Licenses 1050 York Road Towson, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one bause on each line. Interval Between Onset and Death Immediate Cause (Final less Physician/ rincotic disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examine burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical certificate be Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23d. Date of delivery HSP. 23b. Was decedent pregnant Month Day Vear in the past 12 months?

1 Yes 2 No
9 Unknown the Hospital or Attending Physician: The law requires that the death for ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? s been signed b Completed by 1 Yes 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy cate has page 2 s performed? Yes 2 X N certificate 26. Place of Death (Check only one) Be 25. Was case referred to medical Division of Vital Assisted Living examiner? Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 2 🗓 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 27. Manner of Death injury Natural
Accider
Suicide 5 Pending 1 Yes 2 No Accident within 24 hours aner wow.

To the Funeral Director: / Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie, 29c. License number 101 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Curis ST AMON

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day,

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month 01 45 A M Physician Sutton Reginald 21 Jan 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Hospital Agnes 8. Date of Birth (Month, Day, Year If Under 24 Hrs. Birthplace (State or Foreign Country) If Under 1 Year 5. Social Security Number 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) **Funeral** Counti Days Hours Months 06-06-50 216-50-1107 59 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at XXYes 2 □ No Funeral Director MD NA Baltimore the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code death with 4427 Old Frederick Road 21229 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

XXXYes 2 \sum No
If Yes, Give
Year or Dates: Black, White, etc. African and 2 should be filed within 72 hours after of teath and Mental Hygiene. m 27 is marked other than "natural", or iter 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 🛛 No Specify: Specify: American Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Logistics of MD. Parts Saleman 12th Grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sutton Gladys Pierce Reginald မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)2122919a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2.
Department of Health a
Important: If item 27 is
any injury or other trau 4427 Old Frederick Road Baltimore, MD Joan R. Sutton-Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 02-02-10 Owings Mills, MD Garrison Forest 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home P.A. Street Baltimore, MD 21217 Gilmor 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only the cause on each line. Immediate Cause (Final Decompensated

Due to (or as a consequence of): **Physician** disease or condition resulting in death) Cirrhosis Months /Medical **Examiner** Years Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events certificate be executed Diabetic Mellitus years and-trar resulting in death) Last Due to (or as a consequence of) .09289 attending physician a for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy Year Month 5 Other (specify) □Yes 2□No signed by the o. 9 Unknown 9 Unknown 9. 23a. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, δ 1 | Yes 2 | No 3 | Probably 4 \ Unknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 ☐ Yes 2 🗹 No certificate 2 No 1 ☐ Yes Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2≅No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To of this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Division 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. Director / 2 ☐ Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral D To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier MD 2010 00 69 177 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

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32. Registrar's Signature

Valikhani

Mohammad 31. Date filed (Month, Day, Year)

JAN 22 2010

Battimore

21229

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** January 10, 2010 3:00 PM M Erwin Schmitz /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel 5234 Mozart Terrace Lothian If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, May 1, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 X M 2 □ F 543-42-8749 Germany Director 81 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, its Medical Evanitation that any once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b County 1 ☐ Yes 2 ☑ No Funeral Director Anne Arundel Lothian MD 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20711 5234 Mozart Terrace 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 X No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2X Married white 1 ∐Yes 21XINo Specify: Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) construction brick mason 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alwine Potten Wilhelm Georg Schmitz ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5234 Mozasrt Terrace Lothian, MD 20711 19a. Informant's Name/Relationship (Type. Print) Doris V. Schmitz/spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4X Donation 5 ☐ Other (Specify) Signature of Funeral Serv State Anatomy Board 655 W. Baltimore Street Baltimore, MD 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Ca (Final RESPIRATORY ACVITE **Physician** disease or condition resulting in death) , /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Physician/Medical Examiner NEUMONIA for use as the burial-tran that initiated events resulting in death) Last and Due to (or as a consequence of): physician IE EEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 Tyes 2 No sbeen signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 3 Probably 4 Unknown 2 🗌 No 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? page 2 After this certificate funeral director, pag 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 5 Pending investigation 1. Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, or Attending Physician; ours after death.

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filled in by the fu death.

Baltimore, Maryland 21215-0036

within 24 hours a

To the Funeral C

completely filled To the Hospital

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PKWY, ANNAPOLIS IMD Scott EDEN M, D 2002 MEDICAL 32 Registrar's Signature 31. Date filed (Ma

State Registrar 30

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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	Funeral Director		5. Social Security N 218-46-29	900 1	6. Sex 7. Age (In yrs. last birtho				If Under 1 Year If Under 24 Hrs. Months Days Hours Min.			8. Date of Birth (Month, Day, Yea. 12–05–195		Birthp Coun	lace (State stry) MD	or Foreign
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Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year 01-20-20 PO **Physician** 610 A Rose D. Schueler /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford 419 Abbey Circle Abingdon 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Funeral 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country)
 MD Months Days Hours 1 □ M 2 🛱 F 88 MD 218-12-7342 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show Pages 1 and 2 should be filed within 72 hours after death with the Maryla ment of Health and Mental Hyglene. The titlem 23a or 28a-f shown it flem 27 is marked other than "natural", or items 23a or 28a-f shown in the context traumatic event, "the Medical Exyminar must be required at any or other traumatic event, "the Medical Exyminar must be required at 1 ☐ Yes 2 No Director Harford Abingdon 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 419 Abbey Circle 21009 USA by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home maker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Antonietta Roggio Joseph Fontanazza 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau 1424 My Ladys Drive Abingdon, MD 21009 Rita Mazziott (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 01-23-2010 Most Holy Redeemer Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Home of BelAir 21. Signature of Funeral Service Licensee Inc 610 W. MacPhail Rd Bel Air, MD 21014 23a. Dert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) neumonia 1241 /Medical Due to (or as a consequence of) Examiner Due to or as a consequence of): Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Examiner law requires that the death certificate be executed burial-tran Due to (or as a consequence of) P.O. Box 68760. ed by the attending physician detached for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 CHF 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No After this certificate has autopsy performe Cread spital or Attending Physician; The hours after death.
Ineral Director; After this certificate by filled in by the funeral director, pag 1 □ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Hesidence} \) 6 \(\text{Other} \(\text{Other} \) (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital o within 24 hours aff To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

Division of Vital Records,

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State Registrar

(Check only one)

29b. Signature and title of certifie

Kloes 31. Date filed (Month, Day, Year)

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and manner stated.

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29c. License number

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic svent, II a Medic once. **Physician** /Medical Examiner to the Hospital or Attending Physicien: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

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29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1 ther 8600 Wa 32. Registrant Signature

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BOULOUAND PORTU, 11-, MD 21234

January 18 2010

29d. Date signed (Month, Day, Year)

29c. License number

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Ye a Physician 23 55 01 20 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 1 ₩ 2 □ F 217-26-5997 78 Director MD April 4,1931 Usual Residence of Decedent 10h County 10c. City, Town or Location 10d. Inside City Limits woys 10a. State ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, it is it welloal Experiment inst by notified at Director Frederick MD Frederick 1 ☐ Yes ≱ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 6351 Springridge Parkway #238 21701 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Xes 2 ☐ No If Yes, Give Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 72 hours after 1 ☐ Never Married 2 ☑ Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: ⋛ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) filed within 7 I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Policeman Baltimore City 12th 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othany Injury or other traumatic event 18. Mother's Name (First, Middle, Maiden Surname) Be Ruth Collins John N. Schoff ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6351 Springridge Parkway Frederick MD 19a. Informant's Name/Relationship (Type. Print) Helen Schoff /wife altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Bayview Crematory 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore MD 12010 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** nossive bleeding This disease or condition resulting in death) 1210 /Medical Due to (or as a consequence of); Examiner all Wilh Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) and burial-tran Due to (or as a consequence of): Physician/Medical OF THE CATION APPROVED BY MEDICAL PROMISE the attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) P.O. the 9 Unknown 9 Unknown Ś signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 3 1 Yes 2 No 3 Probably 4 Unknown certificate has been si irector, page 2 should t Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ☐ Yes 2 ☐ No Division of Vital 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 7 No death. 2 Accident investigation within 24 hours after death

To the Funeral Director:
completely filled in by the 1 01.20.2010 1200 ellen Curb from Standing ☐Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 180 Tue Mas Johnson Drive determined 4 Thomicide Hospital or Office P building FREDERICK m) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

State

Wilinda J. Moston

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ORIGINAL

32. Registrar's Signature

Baltimore, mo

				Please	e Type or Pri							_		_	le.	
		-	For State Registrar		State of M	aryland			nt of F te of L		nd Me	ental Hy	/giene Reg. No	-201	0	01318
	Physicia Medic		1. Decedent's Name	(First, Middle, Lannine	Schuett							2. Date of De Month Januar	eath	ö, 2016	Br Br	3. Time of Death 7:50 P M
	Examin		4a. Facility Name (if n		re street and number) Hospice			4b. Cit	4b. City, Town, or Location of Death Timonium			4c. County of Deat Bal timore			Death Ce	
	Funeral Director		5. Social Security Nur 213-28-5		Sex 1 □ M 2 X F	e (In yrs. Ia: 81	st birthday) Yrs.	If Und Months	er 1 Year Days	If Under 24 Hours	Hrs. 8 Min.	B. Date of Bi (Month, Di Oct. 8		g B 1	Birthpla Country	ace (State or Foreign Land
	/aryland 8a-f show tified at	rector	Usual Residence of D 10a. State MD	Decedent 10b. County Har	ford		Town or Loc								10	d. Inside City Limits
	with the N 23a or 2 ust be no	Funeral Director	10e. Street and Number 1909 Er		n Road #	132		10f. Z	ip Code 2101	15			10g. C	tizen of Wha	t Countr	y?
) р.ш. 0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		11. Marital Status 1 □ Never Marrie 3 🏋 Widowed 4		12. Was Decedent I Armed Forces? 1 ☐ Yes 2 X If Yes, Give Year or Dates.	es $2X$ No Give 1 \square Yes $2X$ No Specify:				ın, Mexican, F	? (Speci uerto Ri	fy Yes or No can, etc.)	-		14. Race - American Indian, Black, White, etc. Specify: White	
20, 2010 7:50 p. Maryland 21215-0036	vithin 72 houiene. iene. ir than "natu the Medica	Completed by	(Spec.	15. Decedent's ify only highest g nday (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Bank Manager								ind of Busin Bank ing		istry
2010 yland 2	should be filed v n and Mental Hyg 7 is marked othe raumatic event ,	To Be	17. Father's Name (Fi David W							18. Mother's Mar		First, Middle W einkn		Surname)		
7 20,	and 2 shou Health and tem 27 is m			Linzey/	Type, Print) Daughte		705	Ca	rltc	and Number o	r Rural F B	el Air	er, City o	yland2	, <i>Zip</i> Co 101 4	de)
JANUARY Baltimore,	. Page 1 a tment of H tant: If ite jury or oth				Removal from State	EX.	ace of Dispo emetery, cren aps 1 F ape 1 –	sition (Na natory or unge	ame of other place ra Ai	e) 01	Da 1 /21/	^{te} / 2010		ocation - Cit rest Hi		m, State Maryland
JA Bali	permit. Departr Importa any inju		21. Signature of Fund	eral Service Licer	E Nale	}	8 8	Vame 800	s Addres Fu Har	sof Facility neral ford	Ch Roa	apel &	Crem kvill	ationS e, Mary	ervio Land	21234
N.S.	Physician/ Medical Examiner Physician and Examiner	cal Examiner	23a. Flart 1. Enter the chock, or heart Immediate Cause (Fi disease or condition resulting in death) Sequentially list condition in the condition of the condi	failure. List only ina! ditions, nediate ying njury	pplications that caused one cause on each line a. CHRONIC Due to (or as: b. Due to (or as: c. Due to (or as:	OBST a conseque	RUCTIVence of):						rrest,			Approximate nterval Between Onset and Death
:TT . Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate to within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompleted filled in by the funeral director, page 2 should be detached for use as the total states.	by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1											y Day Year		
JEANNINE SCHUETT Vital Records, P.O. Box	Physician: The law requires that the death this certificate has been signed by the atterral director, page 2 should be detached for	leted by Pl	Part II. Other signific	cant conditions	contributing to death b	ut not resu	Ilting in the u	nderlying	cause giv	ven in Part I.			Yes 2	□ No 3 [Proba	cause of death? bly 4 Unknown y findings available
JEANNINE	n: The law ficate has or, page 2 s	Completed	25. Was case referred	to medical					Qe Di	ace of Death (auto perf 1 Yes	opsy ormed?	prior	to com	pletion of cause of
	nysicia nis cert	To Be	examiner? 1 Yes 2 X		Hospital:	ent 2 🗆 E	ER/Outpatien	t 3 🗆 [Othe	or:			idence 6	X Other (S	pecify)	HOSPICE
n of	ding Pl th. After th funeral		27. Manner of Death 1 Natural 2 Accident	5 Pending	28a. Date of inju (Month, Day	ry /, Yea <i>r</i>)	28b. Time of injury	М	28c. Injury work	yat ? Yes 2 □ No	- 1	d. Describe	how injur	y occurred		
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completed filled in by the fune	l Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 Could not determined	be 200 Place of Inju	ury - At hor c. (Specify)	ne, farm, stre					f. Location (City or To			Rural R	oute Number,
	Hospital 24 hours Euneral Eted filled	Medical	29a. Certifier 1 [(Check 2 [only one) 3	Medical Exam	ysician: To the best of niner: On the basis of earse Practioner: To the	xamination	and/or invest	igation, ir	n my opinio	on, death occur	red at th	e time, date	and place	, and due to	the cause	e(s) and manner state
	To the within To the comple	2	29b. Signature and tit			Soci of my	iniomodgo, c		c. License		a pidoo,	and due to t		te signed (M		
			30. Name and address	ss of person who	completed cause of de	eath (Item :	23a) (Type , P	rint)	1314	7/12	• [121/2	010	
	12		JACKIE JO 31. Date filed (Month,						RD.	TIMONI	JM,	MD_210	093			
	Stat Registra			JAN 22	2010 Sens	www.	A. A	BOLK								

Registrar

JAN22

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 0 01320 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 3:20 P M 2010 Zelma A. Sedlins January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rockville Montgomery National Lutheran Home 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Funeral April I, 1913 1 □ M 2 🗓 F Months Davs Hours 326-30-6271 96 Latvia **Director** Usual Residence of Decedent or 28a-f shov notified at 10a, State 10b. County 10c. City. Town or Location 10d Inside City Limits filed within 72 hours after death with the Maryland Director 1 Yes 2X No Maryland Rockville Montgomery 10e. Street and Number 10f. Zip Code 5 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be i Funeral 9701 Veirs Drive 20850 Latvia Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. ģ 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 X Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Kristine Riekstins Rudolfs Matisons 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 50, Wilton, Connecticut 06897 Malda Liventals / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State January 28, 1 🗆 Burial 2 🕅 Cremation 3 🗆 Removal from State Montgomery Crematorium, Inc Bethesda, Maryland 4 Donation 5 Other (Specify) 2010 Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 21. Signature of Funeral Service Licenses 20850-2805 23a. Part 1. Eyer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or n spiratory arrest, shock, or heart failure. List only one cause on the line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine cause. Enter Underlying the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi Cause (Disease or iinjury that initiated events and resulting in death) Last Due to (or as a consequence of): physician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Day Month Year ☐ Pregnant at time of death ☐ Unknown 2 KIO page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy 1 Yes completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital 1 ☐ Yes 2 ☑ No Other: မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 Natural injury 5 Pending after death. 🗓 Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a To the Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only-one) 29b. Signature and title of certifier 29c License number

State

Registrar

26033 Ridge Road, Damascus, Maryland 20872

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Charles W. Karesh, ate filed (Month, Day, Year)

JAN 2 2 2010

MD

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Dimitrios Stroumpoulis Physician/ Month Year Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Saint Joseph Medical Center Baltimore Towson | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Jan. 28 5. Social Security Numbe 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** . 19<u>25</u> 1 XM 2 1 84 N/A Greece Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Nea Smyrni, Athens N/A N/A 1 🗌 Yes 2 ื No 10e. Street and Number 10g. Citizen of What Country? Funeral 4 Patriarchou Grigoriou E' Street Gr-17124 Greece 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: If Yes, Give Specify: White 3 Midowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Physician Medical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Michail Stroumpoulis Anastasia Zourntou 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |Michail Strouboulis / Son 12 Maymont Court Timonium, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 X Removal from State cemetery, crematory or other place unk unk Greece 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Section 1. 22. Name and Address of Facility Ruck Towson Funeral 1050 York Road Towson, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Due to (or as a consequence of): Medical Examiner VENTILATORY FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury PMEEKS Examiner Due to (or as a consequence oi). the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Pregnant at time of death Dav Year 1 Yes 2 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ADULT RESPIRATORY DISTRESS SYNDROME 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records. 2 No 3 Probably 4 Unknown Certificate: To Be Completed 24b. Were autopsy findings available prior to completion of cause of death? INTERSTIAL PNEUMONITIS 24a. Was an autopsy perform Yes 2 1 Yes within 24 hours after death.

To the Funeral Director: After this certific: completed filled in by the funeral director, I 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 Z W Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Sia natur 29c. License number 29d. Date signed (Month, Day, Year) D35453

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year,

DRIVE TOWSON,

d address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** Curtis 10,0m05m TAN 2010 CEUSEY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CROSS HOSPITAL SPRINGS MONTGOMER SILVER If Under 1 Year | If Under 24 Hrs. | Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Months Days 218-10-8399 Hours Yrs UNE Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 28a-f show 1 Yes 2 No GAITHEKS BURG Funeral Director MO MONTGOMER 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 23a or 20886 20130 5404 KOTH BURY LANG Int USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 17 Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 14. Race - American Indian, 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: BLACK þ 3 Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) US 60V. Elementary/Secondary (0-12) College (1-4or 5+) BETHESDA NAVAVHOSP. House KEGPING 6 74 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Melonee Keys LUTHER THOMPSON ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Thompson (wife 20130 Rothbury Lane Apt 5405 Gaithersby MO 20886 Pages 1 and 2 ment of Health a Dorothu 27 Department of Hes Important: If item 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ■ Burial 2 Cremation 3 Removal from State EDENEZEVUMC Cem. NAN 24,2010 IJAMSVILLE MD any injury or 4 ☐ Donation 5 ☐ Other (Specify) L. ROLLINS FUN. Home 22. Name and Address of Facility ARY 21. Signature of Funeral Service Licenses nun α . WOT SOUTH ST FREDERICA MD 21701 Approximate Interval Between Onset and Death 23a. Part 1. Enter the lisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear lailure. List only one cause on each line. Immediate Cause (Final SEPTICEMIA Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner NOUM ONUA Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 - Ectopic pregnancy 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 I Inknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 4 CMONARY FIBRUSIS 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 □ Yes 2 🗖 No 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home 5 \sum Residence 6 \subseteq Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manper of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 🗹 Natural 5 Pending investigation 1 🗌 Yes 2 🗌 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

To the Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760, P.O. Division of Vital Records, within 24 hours after death.

To the Funeral Director; After this certific completely filled in by the funeral director, within 24 hours a

Medical Certification: To

State Registrar

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

29b. Signature and title of certifier

D0061937

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) - 1500 FOREST GLOW RD SUNDA SPRINGS MO CANDACE C. WILSON MD

31. Date filed (Month, Day, Year)

4 Homicide

29a. Certifier



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 1:30 P Richard Paul Talbott 15°, 20ĬÛ January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Baltimore Parkville 2913 Linganore Avenue If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
Maryland Social Security Number 8. Date of Birth (Month, Day, Year) June 3, 1949 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1**X** M 2□ F 60 213-50-7973 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland traumatic event, the Proficel Examinational be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Parkville Baltimore 1 ☐ Yes 2 🎇 No Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2913 Linganore Avenue 21234 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married 1X]Yes 2 ☐ No If Yes, Give 7 Baltimore, Maryland 21215-0036 1 □Yes 2 🕎 No Specify: Specify: White þ Vietnam 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Maryland State Elementary/Secondary (0-12) College (1-4or 5+) Computer Programmer Covernment 12 Pages 1 and 2 should be filed vent of Health and Mental Hygident: If Item 27 Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Talbott Isabelle McKeowne 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Item 27 l Cheryl Talbott/ Wife 2913 Linganore Avenue, Parkville, MD 21234 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Evans Funeral Chapel - Bel Air permit. Pages Department of Important: If it any Injury or o 1 ☐ Burial 2XI Cremation 3 ☐ Removal from State 01/18/2010 Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Evans Funeral Chapel & Cremation Services 8800 Harford Road, Parkville, Maryland 21234 21. Signature of Funeral Service Licensee 7-rt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** nimites /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine or Attending Physician: The law requires that the death certificate be executed burial-transi Box 68760. Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 🗌 Ectopic pregnancy in the past 12 months? Month 5 ☐ Other (specify) TYes 2 No. o cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe certificate 1 ∐Yes 2 XNo 2 🗆 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Yes 2 XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Division 1 🔀 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Funeral L 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. within 2. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) January 18, 2010

State Registrar 14th Greene St. Baltimere MD 2120

cause of death (Item 23a) (Type, Print)

32. Regist ar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** TRINH 17 10 Pm HON 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Prince George's Regional hanvel If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign ge (In yrs. last birthday) 89 yrs 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 ☐ M 2 🔽 F Months Vietnam Director /1/1921 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show Director MD 1 ☐ Yes 2 ☑ No Montgomery Burtonsville traumatic event, the Medical Ever-inserroust be notified 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ō 14318 Duvall Hill Court 20866 USA items 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 72 hours after 1 ☐ Never Married 2 ☐ Married ☐Yes 2√No Baltimore, Maryland 21215-0036 'n, If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No ģ Specify: Asian 3√Widewed 4 ☐ Divorced 'natural", Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home permit. Pages 1 and 2 should be filed i Department of Health and Mental Hygii Important: If item 27 is marked other any Injury or other traumatic event, III 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Thi Ha Minh Trinh 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5213 Woodam Court, Columbia, MD 21044 Quang Tran, son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Chesapeake Crematory 1/22/2010 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) MO1559 22. Name and Address of Facility Rapp Funeral & Cremation Svcs. 21. Signature of Funeral Service License 933 Gist Ave. Silver Spring, MD 20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician De hydration disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed attending physician and for use as the burial-tran Box 68760, ST Physician/Medical Non IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🔲 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) P.O. signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown The subsourts nemia Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l page 2 s autopsy performed certificate Mental 2 □ No Rtag 1 ☐ Yes 2 🔀 No 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 □ Yes 2 □ No 2 ☐ Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year)

State Registrar 31. Date file

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

dede

D68782

Laurel Regional

		-	State of Maryland / Dep		d Mental Hy	~ ~ 1 ~	01325
			Registrar 1. Decedent's Name (First, Middle, Last)	rtificate of Death	2. Date of Dea	Reg. No 2010	
	Physicia		Barbara Jean Thomas		Month 01	Day Year 17 2010	3. Time of Death
	Medic Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of De		4c. County of Dea	1 0400
_	,		Holy Cross Hospital	Silver Spring		Montgome	ry
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 H Months Days Hours M		h 9. Bir v, Year) Co	thplace (State or Foreign
H	Director		242-70-3530 G4 Yrs. Usual Residence of Decedent		in. 02/06/I	.945	NC NC
	and show I at	io.	10a. State 10b. County 10c. City, Town or Lo	cation			10d. Inside City Limits
	Maryl 28a-f otifie	Director	MD Prince George's Oxon Hill				1X Yes 2 ☐ No
	h the Saor be n	al D	10e. Street and Number	10f. Zip Code		10g. Citizen of What Co	ountry?
	tth wit ms 2; must	Funeral	5221 Leverett St. 11 Marital Status 12. Was Decedent Ever in U.S. 13.	20745	(Cassify Van av Na	USA	
(0	er dea or ite niner	by Fi	11. Marital Status 1 □ Never Married 2 □ Married 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No	Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu	erto Rican, etc.)	14. Race - Ame Black, Whit	
99	rs afte iral", Exar	ed b	3 ☐ Widowed 4 🖾 Divorced If Yes, Give Year or Dates.	1 ☐ Yes 2 🛣 No Specify:		Specify: B1	ack
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Baltimore, Maryland 21215-0036	led wi Hygid other ent, t	Be (17. Father's Name (First, Middle, Last)		Name (First, Middle,		VCIMION
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≥,	nd 2 sealth m 27			3 Foust St. Acco	keek MD 2	20607	
lore	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		I Dunal 2 Decination 3 Differentiation state	matory or other place)	Date	20c. Location - City or	Town, State
ΕĒ	iit. Par intmer intant injury		4 □ Donation 5 ₺ Other (Specify)Entombment Ft. Linc 21. Signature of Funeral Service Licensee 2	coln Cem. 1/2 2. Name and Address of Facility	23/2010	Brentwood,	
Ba	Deps Impo		N A	2. Name and Address of Facility 1			Olife
П			23a. Par 1. Enter the disease, or complications that caused the death. Do not ent				Approximate
4	nysician/	į,	sMck, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Lung Cancer			11	Interval Between Onset and Death months
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Box 687	ath certifica attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months?	Ectopic pregnancy		23d. Date of de Month	livery Day Year
ğ	the dea by the a tached f	ysic	1 ☐ Yes 2 🛣 No 4 ☐ Pregnant at time of death 5 ☐ 9 ☐ Unknown	Other (specify)		WOTEN	Say Toal
P.O.	hat thed by	by Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did to	bacco use contribute to	the cause of death?
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<u>ra</u>	cian; ertific ector,		25. Was case referred to medical examiner?	26. Place of Death (C			
<u> </u>	Physician: this certific ral director,	2	1 ☐ Yes 2 ☑ No ☐ 1 ☑ Inpatient 2 ☐ ER/Outpatie 27. Manner of Death			lence 6 Other (Spec	cify)
0 1	ding F th. After funer	Certificate:	1 Matural 5 ☐ Pending (Month, Day, Year) 2 ☐ Accident Investigation	t 28c. Injury at work? M 1 □ Yes 2 □ No	28d. Describe h	ow injury occurred	
sio	II or Attend after death Director: /	ıtiti	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, sti			treet and Number or Ru	ıral Route Number,
Division of Vital Records,	tal or		building, etc. (Specify)		City or Tow	n, State)	
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within Ed Hours 4 hours affect death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical	29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation)	occured at the time, date and place	e, and due to the cau	use(s) and manner as stand place, and due to the	ated.
1)	the lithin 2 the lomple	Me	on type (a) 3 _ Curtifying Nurse Creditioner To the best of my knowledge. 29b. Signature and title of certifier		place, and due to the	cause(s) and mainer as	stat «d
3	⊭శ⊭ఠ		· - / 1/16/	DO O 6/887		29d. Date signed (Mont	, ,
	5		30. Name and address of person who completed cause of death (Item 23a) (Type,			01/17/2010	
	w)		Ira Rabin, MD 1500 Forest Glen	,	ng, MD 209	910	
	Stat		31. Date filed (Month, Day, Year) 32. Rejectrar's Signature		J		
	Registra	ır	JAN 2 2 2010 Lener A. A	faces			

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month OROTHI 2011 1:15 PM Medical 4a. Facility Name (if not institution. Examiner 4c. County of Death Baltmorp verlea 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 🐉 🗆 F 103 218-01-0197 Director 2/15/1906 Usual Residence of Decedent shov 10b. County 10a. State 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits death with the Maryland Director 28a-f N/A Baltimore Yes 2 No 10e. Street and Number 9 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 21215 3820 W. Coldspring Lane USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ō 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates. permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item ZT is marked other than "natural", or any injury or other traumatic event, the Medical Examio gines. þ Baltimore, Maryland 21215-0036 African 1 ☐ Yes 2 ☐ No Specify: 3 ₩ Widowed 4 Divorced Completed 16b. Kind of Business Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Factory Clothing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Julia Ann Moore Horace Moore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shelly Sembly/Great Niece 3616 Courtleigh Dr., Balt., MD 21133 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 1/19/10 Hanover,MD Ardent Crematory 4 Donation 5 Other (Specify) 22. Name and Address of Facility Hari, P. 21. Signature of Five al Service Licensee CLose F.Svs MD 21206-51 Belair Rd, Balt. , MD 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Physician disease or condition Medical resulting in death) **Examiner** Sequentially list conditions cause. Enter Underlying Examin Cause (Disease or iinjury that initiated events this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be a within 24 hours after death.

To the Funeral Director that this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the burn completed filled in by the funeral director, page 2 should be detached for use as the burn and the complete of the page 2 should be detached for use as the burn and the page 2 should be detached for use as the burn and the page 2 should be detached for use as the burn and the page 2 should be detached for use as the burn and the page 2 should be detached for the page 2 should be detached for the page 3 should be page 3 should be a should be page 3 should be a P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 month 1 Yes 2 No 5 Other (specify) Month Year Day Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 🗌 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: ဂ္ 1 Tes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred injury Natural 5 Pending 1 Yes 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Contrigued by the Practice of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Contrigued by the Practice of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check

Registrar DHMH 17 Rev 7/2009

State

29b. Signature and title of

istrar's Signature

560

Raven B

29d. Date signed (Month, Day, Year) 19-2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deat 3. Time of Death Physician/ Month 30P M 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner Vursina Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 😿 F Hours Min. Country) -26 Director Yrs Usual Residence of Decedent or items 23a or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show 10b. County 10c. City, Town or Location injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Completed by Funeral 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-11, Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No If Yes, Give Specify: 3 ☑ Widowed 4 ☐ Divorced Year or Dates 190 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) taine Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ 19a. Informant's Name/Relationship (Type, Print) Kena Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 1 🗹 Burial 2 🗆 Cremation 3 🗹 emetery, crematon Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 8 23a. Part 1. Enjecthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician, disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) use as the burial-transi Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death Other (specify) Day ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed 2 🗌 No 1 Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital Other: 2 2 No ᅆ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Hursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes Certificate: 28d. Describe how injury occurred injury 1d Natural 5 Pending 2 🗀 No Investigation Accident within 24 hours after death To the Funeral Director. Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one

State Registrar 29b. Signature and title of certifier

30. Name and address of person

Year

31. Date filed (Month, Day,

cause of death (Item 28a) (Type Print)

egistrar's Signature

29c. License numbe

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death January 17, 2010 **Physician** 6:17 a. M Woo Sueh /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Montgomery Rockville 8. Date of Birth (Month, Day, July 9, If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign Country) China 7. Age (In yrs. last birthday, 5. Social Security Number Funeral 1**X**XM 2□ F 1919 90 Director 127-24-4310 Usual Residence of Decedent the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a State 10h County 28a-f show d other than "natural", or items 23a or 28a-f shov event, the Medical Examiner must be notified at MD Montgomery Rockville 1 Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? United States 600-A Viers Mill Rd. 20852 Funeral death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. and the fire and 1 should also anti-fit item 27 is marked other than "natural", or ite ury or other traumatic event, Ite Medical Examina ury or other traumatic event, Ite Medical Examina 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 □ No Specify: Asian by 3XXWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Embassy (China) Assistant Attache 4 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (Unknown) ဥ (Unknown) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Lina Snyder (daughter) P.O. Box 183, Cabin John, MD 20818 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of Important: If it any Injury or o 1 Surial 2 ☐ Cremation 3 ☐ Removal from State Silver Spring, MD. Gate of Heaven Cem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rapp Funeral & Cremation Service 21. Signature of Funeral Service Licensee M00982 933 Gist Ave. Silver Spring, MD 20910 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 15 min **Physician** Ventricular Tachycardia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Years <u>Coronary Artery</u> Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 Doo

9 Unknown Year Month Day 5 ☐ Other (specify) P.0. been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 3 Probably 4 Unknown 1 ☐ Yes 2 No pneumonia 24b. Were autopsy findings available prior to completion of cause of death? Gastrointestinal Bleeding 24a. Was an certificate has triector, page 2 sl autopsy performe 1 ☐Yes 2 ☐ No 2 No t ☐ Yes Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this funeral 27. Manner of Death 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred After Natural 2 Accident 5 Pending investigation s after dec. ral Director: Aftr 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide ō within 24 hours a 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number Shama 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 14816 PHYSICIANS LN #152, ROCKUILLE MD 20850 JHAMA RAVI MITTAL M.D 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

1. porte

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death Month Day Year JOsephine C. Whitehead 2010 014a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery 1111 O'Sage At. Silver Spring 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 04 07 190 6 Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 1 M 2 TE 578-20-7300 106 1903 ΜĎ Usual Residence of Decedent 10c. City, Town or Location 10h County 10d. Inside City Limits M Yes 2 No Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1111 O"Sage Street 20910 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☑No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Black 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Wilkins Coffee Elementary/Secondary (0-12) 12th. College (1-4or 5+) Manager Manufacturing Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Louis Clifton MAry Shields 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Claude Clifton/Nephew 1111 O'Sage St. Silver Spring, MD. 20910 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 1 - 22 - 10Landover, MD. Harmony Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee MArshall's Funeral Home Mars 4217 9th. St. N.W. Washington, D.C. 20011 23a. Par 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, flock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ② No Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? vascular 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 ☐ Yes 2 ■ No 1 ☐ Yes 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ■ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Physician /Medical Examiner The law requires that the death certificate be executed

Physician

/Medical

Examiner

10a State

MD

Director

Funeral

2

Completed

Be

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Funeral

Director

?7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Madical Evantimer must be notified

and 2 should be filed within 72 hours after teath and Mental Hygiene.

77 Is marked other than "natural", or ite

item 27

permit. Pages 1 a
Department of Her
Important: If item
any injury or othe

Baltimore, Maryland 21215-0036

death

Examiner burial-transi the as nse for 1

and physician attending ed by the signed by t peen has page certificate this After 1

P.O.

Records,

Division of Vital

Physician:

or Attending

Hospital

Physician/Medical ģ Completed Be Medical Certification: To within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fur

25. Was case referred to medical

1∏Yes 2₩No 27. Manner of Death 1 Natural 5 Pending

2 Accident 3 ☐ Suicide 4 Homicide

(Check only one)

29a. Certifier

investigation 6 ☐ Could not be determined

example Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

28a. Date of Injury (Month, Day, Year) 28b. Time of

1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

Crossroads, Bultimore, Mel 21208

State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 4:00 P. M 18, JANUARY 2010 SUZANNE L. WEIDEL /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE 4604 LONG GREEN ROAD GLEN ARM Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 1 □ M 2 □XF 2/18/1933 MARYLAND Director 213-30-3571 76 Usual Residence of Decedent 10d. Inside City Limits 10h County 10c. City, Town or Location 10a. State 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, I'v. Mcdical Evantar must be notified at 1 ☐ Yes 2 X No Director BALTIMORE GLEN ARM MD 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number death with 21057 USA 4604 LONG GREEN ROAD Funeral 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 XNo Saltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify. WHITE \$ 3 XWidowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 73 h and Mental Hygiene. 7 is marked other than "n Elementary/Secondary (0-12) College (1-4or 5+) LIBRARY ARTIST YEARS 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be STELLA BURBA ပ STANLEY SIUTA Pages 1 and 2 should 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If Item 27 is any Injury or other trauonce. JOPPA. MD 25 FORT HOYLE RD. FRED WEIDEL/SON 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ST. JOHN CEMETERY 1/23/2010 HYDES, 4 ☐ Donation 5 ☐ Other (Specify) MD 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 21. Signature of Funeral Service Ucensee 8521 LOCH RAVEN BLVD. TOWSON, MD REM 23a. Part 1. Enter the disease, or convilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner M Slee 10 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner attending physician and for use as the burial-transi Due to (or as a consequence of): P.O. Box 68760 Smoke IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) s been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1⊠Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed 1 ☐ Yes 2 ☐ No certificate 1 ☐ Yes Hospital or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. ours after death.

neral Director: A
filled in by the for 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral is completely filled LE Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2010 20 PITYSICIAN 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) mount Are 515 N00 R 32. Registrar's Signature 31. Date filed (Mg

State Registrar



State of Maryland / Department of Health and Mental Hygiene 01331 2010 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death 3. Time of Death Medical Examiner Joseph Harry Zeno Month 1142 hrs January 8, 2010 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death 20 Box Hill S. Parkway #309 Abingdon Harford 5. Social Security Number **Funeral** 7. Age (In vrs. last birthday) If Under 1 Year 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 24Hrs. Director 325-32-2276 Months 68 Days Hours Min oreian 1 X M 2 F Country) 1941 29 Aug. IL Usual Residence of Decedent 10a. State 10c. City. Town or Location 10d. Inside City Limits s 23a or 28a-f show e notified at once, 28a-f show Yes 2 No Harford permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other reaumatic event, the Medical Examiner must be notified at once. Abingdon 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 20 Box Hill S. Pkwy #309 21009 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No "natural", or items 14. Race - American Indian, Black, Armed Forces 1 Never Married 2 Married If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. 1 X Yes 4 X Divorced If Yes, Give Year 1961-1964 other than "natural", 3 Widowed 1 Yes 2 X No specify: SpecifyWhite Š 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Owner Retail Dry Goods 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be James Vincent Zeno Margaret Beck 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Zeno (Brother) 22 Winthrop New Rd. Sugar Grove, IL 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery. Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State crematory or other place) 1/15/10 Metropolitan Crematory Donation 5 Other Specify Alexandria, VA Signature of Funeral Service Licensee 22. Name and Address of Facility
Ivins Moravecek Funeral Home Reen 80 E. Burlington St. Riverside, 60546 23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval failure. List only one cause on each line /Medical Between Onset and a Hypertensive Cardiovascular Disease Immediate Cause (Final disease Death Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Examiner if any, leading to immediate Due to (or as a consequence of): cause Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed and Physician/Medical attending physician or use as the burial -UNPENDED AMENDED P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 2 Fetal death 3 Ectopic pregnancy Month Day past 12 months? Year Pregnant at time of Other (Specify) i signed by the atte 1 Yes 2 No 9 Unknown g death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Chronic Obstructive Pulmonary Disease; Chronic Alcoholism 1 Yes 2 No 3 Probably 4 Unknown Completed Division of Vital Records, certificate has been ector, page 2 should 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed death? ✓ Yes 2 No 1 🗸 Yes 2 No 25. Was case referred to medical 26 Place of Death (Check only one) Be this Other₄ Inpatient 2 ER/Outpatient 3 1 🗸 Yes DOA Nursing Home 5 Residence 6 ✓ Other: Scene No After 27. Manner of Death 28a. Date of Injury (Month, Day, Year 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending Certification: 1 V Natural I Director: , ed in by the f death. 5 Pending 1 Yes 2 No 2 Accident Investigation within 24 hours after 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town State) determined To the Funeral Homicide 29a. Certifier 1 (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical To the 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. January 9, 2010 30. Name and address of person who completed cause of death (Item 23a Russell Alexander MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician OPP 10/20 PD Naomi Elizabeth Angert 6:00 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Haure de Grace 4c. County of Death Examiner Harford Memorial Hospital Harford 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖾 F Months Days Hours Min. Mc Gounny) no 216-05-3411 88 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Inportant: If item 27 Is marked other than "natural", or items 23a or 28a-f show with injury or other traumatic event, Ite Wedien Experient must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Havre de Grace 1 Yes 2 □ No Director Horford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States of America 1026 Chesapeake Drive Apt. 40 21078 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 □Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Retail Store Owner Retail 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John W. Nash မ 19a. Informant's Name/Relationship (Type. Print)

Donald Angeric (Siep-son) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 Chesapeake Drive, Havre de Grace, Harrand 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 01/11/2010 Uesi Chesiter, PA RA Ferrisaco. Inc. 4 ☐ Donation 5 ☐ Other (Specify) gnature of Funeral Service Licenses 22. Name and Address of Facility Zellman Functor Home, P.A. 123 S. Vashington Street, Havre ic Grace, Fig. 1. Enter the disease, or com vications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on the last on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): of Vital Records, P.O. Box 68760, physician Physician/Medical the attending p 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Vear Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) 1 □Yes 2 □No ed by the 9 Unknown ate has been signed page 2 should be def Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed ours after death.

eral Director. After this certificate has been filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? res 2 No 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 XNo 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 → Natural 2 □ Accident 5 Pending investigation 1 Tyes 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide To the Hospital within 24 hours a To the Funeral D 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated

Division Seri

> State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

parus 30. Name and address of person who con

poleted cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 8:15 Edward Aker January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** St. Mary's 44338 Ivy Stone Lane California If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 09/06/192 9. Birthplace (State or Foreign **Funeral** 1 🕱 M 2 🗆 F Min. Hours Country) Director 82 180-20-9858 Pennsvlvania Usual Residence of Decedent shov 10a. State 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at 10d. Inside City Limits Director Maryland St. Mary's California 1 Yes 2XXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Page 1 and 2 should be filed within 72 hours after death with the Funeral 20619 USA 44338 Ivy Stone Lane 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Completed by 1 Never Married 2 X Married 1 X Yes If Yes, Give 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify "natural", 3 Widowed 4 Divorced White Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) U.S. Postal Service Postal Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Edward Lewis Aker Jane Fineley McElfresh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 41, California, MD 20619 Katherine Aker/Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 🔲 Burial 2 🔀 Cremation 3 🗎 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 01/12/2010 Charlotte Hall, MD Brinsfield-Echols Signature of Funeral Service Edward N. Bri 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Brinsfield, 22955 Hollywood Rd., Leonardtown, MD 20650 M00052 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause un each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physicians disease or condition Medical resulting in death) Examiner Sequentially list conditions, If any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Exami ed by the attending physician and detached for use as the burial-tran resulting in death) Last Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be in 24 hours after death.

the Funeral Director: After this certificate has been signed by the attending physicis Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year 2 🗆 No 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? this certificate has been signed ral director, page 2 should be det Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an prior to death? autopsy performe 1 Yes 2 No funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 🗌 Yes 2 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year)

Sta

DHMH 17 Rev 7/2009

Registrar

Michael Szkotnicki

22576 MacArthur Blvd., California, MD 20619

death (Item 23a) (Type, Print)

istrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** Ruth E. 2010 5:35A Anderson January /Medical 4c. Counfy of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Montgomery Village Health Care Center Montgomery Village Montgomery Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Hours 1 ☐ M 2 🕏 F Months Days 85 Maryland Director 23 1924 August 579-26-3858 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, Trains Item Examiner must be notified at 1 ☐ Yes 2 X No Director Poolesville Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 19000 Dowden Circle 20837 IISA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □Yes 2 🛣 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 □Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 □Yes 2X No Specify: <u>م</u> Specify. 3 X Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r Montgomery County Elementary/Secondary (0-12) College (1-4or 5+) 12 Teaching Assistant Public School System 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be မ Jesse James Rippeon Carrie Virginia Crum 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and Department of Health Important: if item 27, any injury or other tra once. Health tem 27 i 19000 Dowden Circle, Poolesville, Maryland 20837 Sharon R. Anderson, daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mount Olivet Cemetery 1/8/2010 Frederick, Maryland 21. Signature of Funeral Service Lices 22. Name and Address of FacilitMolesworth-Williams Funeral Home 20872 26401 Ridge Road, Damascus, Maryland Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that initiated events Due to (or as a consequence of): Examine death certificate be executed burial-transi resulting in death) Last Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year 5 Other (specify) cate has been signed by the page 2 should be detached in Ö ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown 1 □ Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2-100 certificate 2 □ No 1 □Yes 1-12 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 DrNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 14 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier

of Vital Records, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Division

> State Registrar

Medical

29b. Signature and title of certifier

32. Registrar's Signature 31. Date filed (Month, Day, Year)

HOOS1280.

29c. License number

29d. Date signed (Month, Day, Year) January 4, 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

10110 Molecular Drive, Rockville, Maryland 20850 Anushiravan Dadgar, M.D.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 04 Yearo 01 Claire Elaine Becker 5:50AM M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Howard Columbia Summerford Assisted Living If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Feb 15, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Hours Days 1 □ M 2 🔽 F Yrs. 213-32-2273 75 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show d other than "natural", or items 23a or 28a-f shovevent, the Medical Examinar must be notified at Ellicott City MD Howard 1 ☐ Yes 2√☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21042 3810 Walt Ann Drive death v Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. within 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. White ģ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, the I' act once. Elementary/Secondary (0-12) College (1-4or 5+) Clerical / Domestic / Homemaker Stenographer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary Elizabeth Austin Jacob Elmer Timanus ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3810~Walt~Ann~Dr.,~Ellicott~City,~MD~2104219a. Informant's Name/Relationship (Type. Print) Mr. Herbert C. Becker (Spouse) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Crestlawn Mem. Gardens 1/7/2010 Marriottsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee PARAME and Address of Facility
HAIGHT FUNERAL HOME & CHAPEL, P.A.
PO Box 195 Sykesville, MD 21784 1100764 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Alzheimer's disease **Physician** years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Examine Due to (or as a consequence of): The law requires that the death certificate be executed signed by the attending physician and is detached for use as the burial-transi resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) □Yes 2 100 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 Essential Hypertension 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an page 2 s autopsy certificate 1 □ Yes 2 [XNo 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Assisted 1∐Yes 2∠No Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 5 Pending investigation To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fun 1 □Yes 2 □ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifiei 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M.D. WIL D56531 Jan 04, 2010

DHMH 17 Rev 1/2001

10

State Registrar 8600 Snowden River Pkwy #301, Columbia, MD 21045

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

M.D.

Harry Li, 31. Date filed (Month, Day, Year)

	Physicia /Medic Examin	a
_		
	Funeral	
	Director	

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

WIL

	•	State Registrar		Cer	tificate	e of Dea	ath		Reg. No	2010	01336
sicia	,	1. Decedent's Name (First, Middle, Last)	0					2. Date of De Month	Da		3. Time of Death
edica			13A	ran				JAN			
mine	r	4a. Facility Name (If not institution, give street and number)				own, or Loca				. County of Dea	
		CArroll Hospital Cette		- A b i-Ab d \	Me If Under	stmi	nder 24 Hrs.		_	CArro	
ral		5. Social Security Number 6. Sex 7. Age 1	9 (in yrs. ia 86	st birthday) Yrs.	Months	Days Ho		8. Date of Bir (Month, Da	a <i>y, Y</i> ea <i>r</i> ,) Co	thplace (State or Foreign
tor	ŀ	Usual Residence of Decedent						Jan 19	, 15	023 Mar	yland
1		10a. State 10b. County	10c. City,	Town or Loc	ation						10d. Inside City Limits
	מַ	Maryland Carroll				Tane	eytown				1 □Yes 2 No
	Director	10e. Street and Number			10f. Zip (Code			10g. C	itizen of What Co	puntry?
	_ 	4150 Fringer Road				2	1787			USA	
	runeral	11. Marital Status 12. Was Decedent E Armed Forces?	Ever in U.S	. 13. W	/as Decede Yes, speci	ent of Hispani fv Cuban, Me	c Origin? (Sp	pecify Yes or No Rican, etc.))-	14. Race - Ame Black, Whit	
1	Dy I	Armed Forces? 1 Never Married 2 Married 1 Yes 2 Married If Yes, Give	10		□Yes 2		ecify:	,		Specify: wh	
	<u> </u>	3 Widowed 4 □ Divorced Year or Dates:		10a Danad	+)-	Occupation			105 1		
	Sec	15. Decedent's Education (Specify only highest grade completed)		(Give k	ents Osuai and of work ONOT use	Occupation done during retired)	most of work	king	16D. P	Kind of Business	industry
	Completed	Elementary/Secondary (0-12) College (1-4or 5	+)		omemal					Own Hom	e
	Š Re Re	17. Father's Name (First, Middle, Last)			3111011101		Nother's Nam	ne (First, Middle	, Maidei	n Surname)	
	0	Andrew Wesolowski				1	Karoli	na Klam	ut		
	7	19a. Informant's Name/Relationship (Type. Print)		19b. Mailing	Address (Street and N	umber or Ru	ral Route Numb	er, City	or Town, State,	Zip Code)
		Thomas Baran, son		4150	Frin	ger Ro	ad, Ta	neytown	, MI	21787	
		20a. Method of Disposition	20b. Pla	ace of Dispos metery, crem	ition (Nam atory or oth	e of ner place)		Date	20c. L	ocation - City or	Town, State
		1 Mathematical Buriat 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		Joseph			01/0	8/2010	Τā	aneytown	, MD
once		21. Signature of Funeral Service Licensee		_		Address of F	Li	yers-Du	rbor	aw Fune	ral Home
a	4	fust K _ Julio								n, MD 21	
	7	23a. Part 1/Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lin	the death.	Do not ente	r the mode	of dying, suc	ch as cardiac	or respiratory a	ırrest,		Approximate Interval Between Onset and Death
an		Immediate Cause (Final disease or condition	ena	1 FI	7 ilu	re					/week
al er		resulting in death) Due to (or as	a conseque	ence of):	-, ,						
	_	Sequentially list conditions, b.	orti	ω S	teno.	515					
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a conseque	ence or):							
	Xa	that initiated events c	a conseque	ence of):							
		d									
	Medical										
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth	of pregnan	icy	Ectopic pro	agnanov				23d. Date of de	
	25	1 Yes 2 No 4 Pregnant at			Other (spe					Month	Day Year
	be completed by Physician	9 🗆 Unknown						00 5:11			
	2	Part II. Other significant conditions contributing to death but Aurtic Stewosis	it not resul	ting in the un	derlying ca	use given in F	art I.				the cause of death?
	2	140rtic STENOSIS						1 🗆	Yes 2		robably 4 Unknown
	<u> </u>							24a. Was auto	psy	24b. Were at prior to	topsy findings available completion of cause of
.	3							1 □ Yes	2 N	death? 1 ☐ Yes	2 □ No
		25. Was case referred to medical examiner?				Othor		th (Check only o			
	<u>:</u>	1 ☐ Yes 24 No Hospital: 14 mpatie 27. Manner of Death 28a. Date of Injul		R/Outpatient 28b. Time of		4 4 4	☐ Nursing H	ome 5 ☐ Resi 28d. Describe		6 ☐ Other (Spe	ecify)
	5	1 Natural 5 ☐ Pending (Month, Day 2 ☐ Accident investigation	(Year)	Injury	м	c. Injury at Work? 1 ∐Yes	2 □ No	Edd. Doddilbo	now myc	ary cocurred	
	3	3 ☐ Suicide 6 ☐ Could not be 28e. Place of Inju	ıry - At hon	ne, farm, stre	et, factory,	office		28f, Location (Street a	nd Number or R	ural Route Number,
	2	4 ☐ Homicide determined building, etc	:. (Бреспу)					City or To	wn, Stat	te)	
.	2	29a. Certifier (Check only (Ch	of my know	rledge, death	occurred a	it the time, da	ite and place	, and due to the	cause(s) and manner a	s stated.
. 3	medical certification: 10	one) and manner sta	ted.					Jo at the time,			
	=	29b. Signature and title of certifier				License num				ate signed (Moni	
	-	,,,,	ni			069	321		Jr	1N. 3	2010
		30. Name and address of person who completed cause of do	eath (Item)	zsa) (Type, P	rint)	rial 1	1/0	1 Wart-	201	to h	10 211 E2
State		30. Name and address of person who completed cause of domesting the second of the seco	ır's Signatu	ire	,a , U '	· (4 /7	,,,,	J+ + + 17.		. 100 11	CI SILV
istra		JAN 0 5 2010 Lans	un	A. 1	back	1					
1/200	1			1							

Registrar

10-00307 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. John Edward Brooks State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar . Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day
January 11, 2010 0857 hrs Medical Examine John Edward Brooks 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Charles Arlough Place 1st Trailer Waldorf If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours Director 06/15/1934 219-30-3105 1 X M 2 F 75 Country)Maryland Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 X No 28a-f show Charles LaPlata notified at once. it. Pages 1 and 2 should be filed within 72 hours after death with the Maryland rument of Health and Mental Hygiene. Transit If liten 27 is marked other than "natural", or items 23a or 28a-f shy y or other transmist event, the Medical Examiner must be notified at once y or other transmitic event, the Medical Examiner must be notified at once rector 10e. Street and Numbe 10f. Zip Code 10g, Citizen of What Country? 20646 United States Arlough Place 1st Trailer 靣 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 2X No Yes If Yes. Give Year 1 Yes 2 X No specify: Specify: Black 3 Widowed 4 Divorced à 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) eted during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 State Highway 6 Laborer 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) Elizabeth Brown Brooks Edward Brooks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5230 Kelley Williams Place, Indian Head, MD 20640 Mildred Williams/Niece 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 1/19/2010 Waldorf, Maryland Heritage Memorial Cem. 4 Donation 5 Other Specify. Thornton Funeral Home, P.A. 3439 Livingston Road, Indian Head, MD 20640 21 signat re of Funeral Service Licenses Lyuna C. Thornton Johnson M00583 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory area; shock or heart of failure. List only one cause on each line. Hypothermia complicating hypertensive atherosciero **Physician** /Medical Immediate Cause (Final disease cardiovascular disease **Examiner** or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last Ж The law requires that the death certificate be executed and Physician/Medical AMENDED 3 a, PII, 27, 28a-f, per EM g901 3/2/10 TT X UNPENDED attending physician or use as the burial Box 68760 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Day Year Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I signed by t Records, P.O. ≧ 1 Yes 2 No 3 Probably 4 V Unknown Chronic alcoholism Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy has performed' death? 1 🗸 Yes ✓ Yes 2 No 2 No page 26.Place of Death (Check only one) Hospital or Attending Physician: 25. Was case referred to medical Division of Vital Hospital: 1 Inpatient 2 Other Nursing Home 5 Residence 6 🗹 Other: Scene ER/Outpatient 3 DOA this 1 🗸 Yes 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d Describe how injury occurre After 28a. Date of Injury (Month, Day, Year) subject exposed to cold Natural 1 Yes 2X No 5 Pending Director: d in by the f Fd 1/11/10 Fd 8:50 am environment 2 X Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number City or Town, State) Ar lough P1. Ist 24 hours after of Funeral Direct Suicide 6 Could not be determined (Specify) Fd: outside residence Homicide Waldorf. 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number OCME January 12, 2010 O.C.M.E. u of death (Item 23a) Name and address of person who completed car Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 2010 Registrar's Signature State

DHMH 17 Rev 1/2001 OCMF 2006

Registra

Uneura.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 01338 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Januaru 2010 6:45 AM Newton Baker Blevins Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Harford Memorial Hospital Havre de Grace Harford If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Virthia 220-22-2102 82 Director Usual Residence of Decedent show Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director 1 Yes 2 No Harkord Havre de Grace 10e. Street and Number 10g, Citizen of What Country? Funeral 720 St. James Terrace 21078 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?,
1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc à 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Tes 2 No Specify Specify: Completed 3 Widowed 4 ☐ Divorced White Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Civil Service Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Alice Roe Newton Howard Blevins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 21078 <u> Melinda Craia (Daughter)</u> Congress Avenue. Havre de Grace. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)

Hariord Memorial Gans 20c. Location - City or Town, State 1 💢 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 01/11/2010 Havre dc Grace. MD 22. Name and Address of Facility Zellman Funeral Home, P.A. Signal e of Funeral Service Licensee Washington St Havre de Grace MD 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only special ous that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, use on each line. Approximate Interval Between Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury that initiated events Due to (or as a consequence of): Due to (or as a consequence of): resulting in death) Last To the Hospital or Attending Physician: The law required towns after death.

Within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician to the Funeral Director. After this certificate has been signed by the attending physician to the Funeral Director, page 2 should be detached for use as the burial programment. Physician/Medical Division of Vital Records, P.O. Box 68760 Blevins, Newtor IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 Vinknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2NO No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No ✓ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending (Month, Day, Year) work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Decrifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practionar: 1. The unit of my how (Check one one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5/0NAO 31. Date filed (Monti 32. Projetrar's Signature State MARRIE . Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - State 1-12-10 Registrar Amend#5.PerInfrmntPGCcr Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Jeremiah N. Booker January Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death <u>Southern Maryland Hospital</u> Clinton 7. Age (In yrs. last birthday If Under 24 Hrs 8. Date of Birth **Funeral** 1 X M 2 □ F Months Days Hours Min. (Month, Day, Year) 06/14/1925 Director Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director MD Prince George's Temple Hills 10e. Street and Number 10f. Zip Code by Funeral 5411 Winston Street 20748 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 X Yes 2 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 X Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) should be filed with and Mental Hygien is marked other th <u> Machinist</u> permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 2 unknown 19a. Informant's Name/Relationship (Type, Print) 5411 Winston St., Temple Hills, MD Robyn Simms/Daughter 20a. Method of Disposition
1 ☐ Burial 2 🗖 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place, 4 Donation 5 Other (Specify) 01/78/5070 | Chesapeake 21. Signature of Funeral Service Disense 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events attending physician and for use as the burial-transit resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Unknown signed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Records, peen: has within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page Yes Division of Vital 25. Was case referred to medica 8 26. Place of Death (Check only one) examiner? Other: 2 🗀 No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c Injury at To the Hospital or Attending 5 Pending 1 Natural injury 1 Yes 2 No Accident Sulcide Investigation Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Postal Service 18. Mother's Name (First, Middle, Maiden Surname) unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20c. Location - City or Town, State Beltsville 22. Name and Address of Facility Strickland Funeral Services Allentown Rd., Camp Springs, MD 20748 Interval Between Onset and Death 23d. Date of delivery Month Day 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy perform death? 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, Cify or Town, State) wledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year)

3. Time of Death

9. Birthplace (State or Foreign

10d. Inside City Limits

1 X Yes 2 No

ll:53A.™

507,0

Prince George's

14. Race - American Indian

Black

Black White etc

4c. County of Death

10g. Citizen of What Country?

16b. Kind of Business Industry

Registrar DHMH 17 Rev 7/2009

State

32. Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Physician Month Bolt Eloise Gray \mathbf{a}^{M} January 5, 201.0 8:15 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Wicomico 1005 Fairwinds Court Salisbury If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 03/07/1922 Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🛣 F Months Hours 579-20-5811 Virginia 87 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland D partment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-4 element in Item 27 is marked other than "natural", or Items 23a or 28a-4 element in Item 25 is marked other than 25 in Market 11 in Market 25 in 18 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Wicomico Salisbury 1 Yes 2 No Director Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21.801 USA 1005 Fairwinds Court Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 M No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes √2 🛂 No Specify: 9 Specify: white 3 X Widowed 4 ☐ Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) National Nucleatory Elementary/Secondary (0-12) College (1-4or 5+) Regulatory Commission 12 telephone operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Wilbur Ruth Gray (unknown) မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1005 Fairwinds Court, Salisbury, MD 21801 Gerald F. Bolt/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Salisbury Crematory Salisbury, MD 1/7/2010 4 □ Donation 5 □ Other (Specify) ²² Name and Address of Facility
Holloway Funeral Home Professional Association
501 Snow Hill Rd., Salisbury, MD 21804 of Funeral Service Licenses Compson CFSP 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ASCUD **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy performed? 1 ☐ Yes 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes a□No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation **V** ■ Natural within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide . Location (Street and Number or Rural Route Number, City or Town, State) determined 4 🗌 Homicide CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1/6/10 1 63199 of person who completed cause of death (Item 23a) (Type, Print) 30. Name and address Yogesh Vohra 614 Eastern Shore Dr., Suite B, Salisbury, MD 21804 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 07 Registrar

			1 - For State Registrar		Maryland / De	epartment Certificate					giene Reg. No.	. U $.$ L)	01341
ı	Physic	ian	1. Decedent's Name (First, Midd. John Caruthers							2. Date of Dea	-		ar	3. Time of Death
	/Medi Exami		4a. Facility Name (If not institutio	n, give street and num	ber)	4b. City,	Town, or I	Location of		January		County of D		11:30 A M
1			Wilson Health	Care Cente	r	Gait					l	ntgome		
	Funeral Director		5. Social Security Number 410–32–3084	6. Sex 1 ★ 2 F	7. Age (In yrs. last birthe	Months	1 Year Days	If Under: Hours		8. Date of Birt Month Day 09/06/	1926		Count	ace (State or Foreign ry) SSSEE
	yłand now		Usual Residence of Decedent 10a. State 10b. County	,	10c. City, Town o	r Location							10	d. Inside City Limits
	with the Maryland e or 28e-f show Le notified at	ctor	MD Montg	omery	Gaithe	rsburg								1 TYes 2 No
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Interpretent: If item 27 is marked other than "neture!; or items 23e or 28e-f show any injury or other treumatic event. The Moulcal Examinating the notified at Once.	Funeral Director	10e. Street and Number 415 Russell Av	enue #511		10f. Zip (-	zen of What ted St		,
	death	nera	11. Marital Status	12. Was Deced	lent Ever in U.S.	13. Was Decede	ent of His	panic Orig	gin? (Spe	cify Yes or No-		14. Race - A	merica	ın Indian,
36	s after , or ite	by Fu	1 Never Married 2 Mar	If Yes, Give	No 1945-	If Yes, speci		, Mexican Specify:	, Puerto I	lican, etc.)		Black, W		
5-0036	2 hour	ted b	3 ☐ Widowed 4 ☐ Divorced	nt's Education	1310	ecedent's Usual	l Occupat					Specify: W		
21215	ithin 7. 18. "n	Completed	(Specify only highe Elementary/Secondary (0-12)	st grade completed) College (1-	4or 5+)	Rive kind of work te. DO NOT use	k done du e retired)	ı <i>ring</i> most	of workin	g		10 0, 500,110	700411101	20119
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Maryland	lid be i lental I ked o ic eve	To Be	John Patrick B	,			1			<i>(First, Middl</i> e, aughn N		,		
lary	2 shou and M Is mar eumat	-	19a. Informant's Name/Relations	ship (Type, Print)	19b. M	ailing Address							ө, <i>Zip</i> (Code)
	1 and Health sm 27 ther tr		Kathryn L. Brod 20a. Method of Disposition	erick / Sp		Russel	L1 Av	re. #						
altimore,	ages ant of I it: If it y or o		1 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		1			10		/2010 M		cation - City		m, State
altir	permit. P Departme Importen any injur		21. Signature of Funeral Service		Memorial	Park C 22. Name and	emet Address			eph Gaw				nc.
В	88 58	0), Y	W. Onth	Mury		5130 Wi						gton,	DC	20016
			23a. Part1. Enter the disease for shock, or heart failure.	complications that car only one cause on ea-	used the death. Do not th line.	enter the mode	of dying,	such as	cardiac or	respiratory arr	est,			Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		Coronary S									Minutes
	Examiner		Considerable for your distance	Corona	ary Artery	Disease	:							
	ad sit	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (o	as a consequence of):								Ī	
,	execut n and al-tran	Examiner	that initiated events resulting in death) Last	c. Due to (or	as a consequence of):				-				+	
8760,	cate be executed obysician and the burial-transit	dicai		d			_							
9	ertifica ding pt	0	IF FEMALE:	00. 1/								-		
Box	feath certifi attending for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birt		3 Ectopic pred					2	3d. Date of o Month		/ Day Year
P.O.	at the de by the tached	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknow	n									
	es tha igned be de	by	Parkinson's Dis	ons contributing to dea	th but not resulting in th	e underlying cau	use given	in Part I.						cause of death?
Records,	w requir been s should	eted	Renal Calculus	sease, nype	rtension,	пуроспу	1010	TSIII,]No 3	Probal	bly 4 □Minknown
Re	The favate has page 2	ompieted	Menar Carearas							24a. Was a autops perform	V	prior t death	to comp	sy findings available pletion of cause of
Vital		Be C	25. Was case referred to medical examiner?					26. Place	of Death	1 ☐ Yes : Check only on	2 🔀 No 18)	1 □ Y	es 2	□ No
of V	Phys this al dii	은	1 ☐ Yes 2 🛣 No	Hospital: 1 ☐ Inp			_	4 LANGAUI		e 5 🗌 Reside			pecify)	
	ding h. After fune	tion	27. Manner of Death 1 ☒ Natural 5 ☐ Pending 2 ☐ Accident investig		Injury 28b. Time Day Year) Injur	of 280 y M	c. Injury a Work? 1 □ Ye	it s 2∐N		ld. Describe ho	ow injury	occurred		
Division	or Attendi after death. Director: A in by the fu	Certification:	3 Suicide 6 Could n	not be	Injury - At home, farm, , etc. (Specify)				-	If. Location (St City or Town	reet and	Number or	Rural I	Route Number,
	To the Hospitel or Al within 24 hours after o To the Funerel Direc completely filled in by	Cer							. 1					
	P Hospitel 24 hours a Funerel I etely filled	edicai	29a. Certifier 1 Certifyin: (Check only 2 Medical I	g Physician: To the be Exeminer: On the base and manner	est of my knowledge, design of examination and/or stated.	eath occurred at investigation, in	the time, n my opin	date and ion, death	l place, ar n occurred	d due to the ca d at the time, d	ause(s) a ate and	and manner place, and d	a <i>s</i> stat lue to tl	ed. he cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier		0		License n	number		2	9d. Date	signed (Mo	nth, Da	ay, Year)
1	2		1 H. Raker	Birsch	howas	D , DO	4115			V	an	uar	4	4,2010
			30. Name and address of person v H. Robet Birsch				1 + L -	w.a.L	an 100				V `	
	Sta Registr		H. Robet Birsch 31. Date filed (Month, Day, Year) JAN 06 20	//32. Reg	istrar's Signature		TINE	rsbur	g,MD	208//				
	negistr	ar	JAN UO ZU	LA CAMBOLLA	1 19. 19 an									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month January 2010 Lilly Mae Beander 3:55 p. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death St. Mary's St. Mary's Nursing Center Leonardtown Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🔯 Days Hours Months Maryland **Director** 218-24-6582 Usual Residence of Decedent or 28a-f show 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director ems 23a or 28a-f sh r must be notified a 1 🗆 Yes 2 🛛 No Maryland St. Mary's Lexington Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 46528 Valley Court, Apt. 3015 20653 items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. ò Black, White, etc. 1 🕅 Never Married 2 🗌 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", 3 Divorced 4 Divorced Specify: Completed Black ed other than "natu event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. Housekeeper Hotel Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked မ Charles Beander Mary Evans 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) <u>.v</u> MD Health tem 27 45998 Great Mills Court, item 2 Stephanie Gibson/Daughter Apt. 306A, Lexington 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State o 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Immaculate Heart of Mary Cemetery Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) 01/08/2010 Lexington Park, MD Signature of Euroral Service ocen ee
Edward N. Brinsfield 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 22955 Hollywood Rd., Leonardtown, MD 20650 M00052 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on val Betwe Immediate Cause (Final Physician disease or condition resulting in death) Medical Examiner Sequentially list conditions, thany, leading to himself cause. Enter Underlying Cause (Disease or linjury Exami attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Physician/ 23b. Was decedent pregnant 23d. Date of delivery 3

Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🐼 No Pregnant at time of death 5 Other (specify) Month signed by the a Unknown g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 🖷 No 3 ☐ Probably 4 ☐ Unknown completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Yes 2 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?
1 ☐ Yes 2 █ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 COther (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending work death. Accident 1 ☐ Yes 2 ☐ No Investigation within 24 hours after deat To the Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 29a. Certifier 👱 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated, Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) completed cause of death (Item 23a) (Type, Print) 30. Name and address of erson 24035 Three Notch Rd., Hollywood, MD 20636 ck M.D. Patri arboe, 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar 32. Registrar's Signature

10-00362 Scott Carl Boroi		Please Type or Print in Black Indelible Ink. Ensu State of Maryland / Department of Health a		
		1- For State Certificate of Death Registrar	Reg. No. 2010	0134
Physicia Medical Examin	n/	1. Decedent's Name (First, Middle,Last) Scott C. Boroi	2. Date of Death Month Day Year January 12, 2010	3. Time of Death 2025 hrs
j			or Location of Death 4c. County of Death	
Funeral		5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Y Months D	ar If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 9. Birth	place (State or Pennsylvania
Director	İ	210-62-5184 1\overline{X} M 2 F 41 Yrs Worlds Besidence of Decedent	03/03/1968 Coul	ntry)
w any		10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits 1 Y Yes 2 No
aryland 8a-f sho	Director	Maryland Dorchester Cambridge 10e. Street and Number 10f. Zip Code	10g. Citizen of What Count	71
th the M 23a or 2 notified	- 1	1006 Locust Street 2163		
fter death wi	/ Funeral		lispanic Origin? (Specify Yes or No- an, Mexican, Puerto Rican, etc.) 14. Race - American, White, etc. White, etc. Specify: Whi	
re, MD 21215-0036 I and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Filem 27 is marked other than "natural", or items 23a or 28a-f show or traumatic event, the Medical Examiner must be notified at once.	Completed by	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working I		•
5-003 ed withii lygiene. other th	Com	12 Locksmith 17. Father's Name (First, Middle, Last)	Lock and 18.Mother's Name (First, Middle, Maiden Surname)	Safe
21215 Ild be fill Mental H marked event, t	To Be	Bernard Boroi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Str	Lois M. Hahn set and Number or Rural Route Number, City or Town, State, J	Zip Code)
MD 3		Barbara A. Berue/Former Wife 119 Beech Ro	oad, Wallingford, PA 19086	
more, ages l an ent of Hea nt: If ite		20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other Specify: 20b. Place of Disposition (Name of orematory or other place) Pagano Cremator	January	
Baltimore, MD 21 permit. Pages I and 2 should Department of Health and Me Important: If liten 27 is ma injury or other traumatice.	Ì		ss of Facility e for Funerals, P.A.	21921
Physician /Medical	1	23a Fart I. Enter the disease, or complications that caused the death. Do not enter the mode of dyir failure. List only one cause on each line.	g, such as cardiac or respiratory arrest, shock, or heart	Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic cardiovascu Due to (or as a consequence of):	ar disease	Death
	اةِ	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):		
ited d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last events resulting in death) Last d.		
), be executed sician and inrial - trans	gica	Y LINPENDED AMENDED	8/10 TT	
5876(prtificate ding phy	ਯ	nast 12 months?	Ectopic pregnancy 23d. Date of delivery Month Da	y Year
Box (death ce the attenced for use	Physici	1 Yes 2 No 9 Unknown 9 Unknown Other (Specify)		
of Vital Records, P.O. Box 68760, ing Physician: The law requires that the death certificate be executed After this certificate has been signed by the attending physician and luneral director, page 2 should be detached for use as the burial - transit	ব	Part II. Other significant conditions contributing to death but not resulting in the underlying cause	given in Part I. 23e. Did tobacco use contribute to the 1 Yes 2 No 3 Proba	*****
ords, tw requir as been s should b	Completed		autopsy prior to co	psy findings available mpletion of cause of
Rec		25. Was case referred to medical 26 Pla	performed? death? 1 ✓ Yes 2 No 1 ✓ Yes te of Death (Check only one)	2 No
Vital hysician this cert	B O	examiner? 1 Yes 2 No Hospital 1 Inpatient 2 ER/Outpatient 3 DOA	Other Nursing Home 5 Residence 6 Other S	Scene
on of anding P rth.	ion:	1X Natural 5 Pending (Month, Day, Year)	ury at Work? 28d. Describe how injury occurred Yes 2 No	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicis completely filled in by the funeral director, page 2 should be detached for use as the burity.	ertification	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) 28e Place of Injury - At home, farm, street, factory, office (Specify)	building, etc. 28f. Location (Street and Number or Rura or Town, State)	I Route Number, City
the Hosp thin 24 hou the Funer mpletely fi	Medical C	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opini		
F 3 F 3	Š.		se number 29d. Date signed (Month	h, Day, Year)
	-	30. Name and address of person who completed cause of death (Item 23a)	.M.E. January 13, 2010	
		Donna M. Vincenti, MD Assistant Medical Examiner 111 Penn Stree	t, Baltimore, MD 21201	
Sta Registr		31 Date filed (Month, Day, Year) 32. Registrar's Signature		
DHMH 17 Rev 1/200	01	OCME ORIGINAL		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Year Virginia Robbins Carr 7010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Wicomica alisba Peninsula Regional Medical center 8. Date of Birth
(Month, Day, Y 9. Birthplace (State or Foreign Country) Maryland 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 1 □ M 2 🔀 F Months Days Hours 213-18-4625 1913 Director Usual Residence of Decedent ifiled within 72 hours are:

tal Hygiene.

ed other than "natural", or items 23a or 28a-f show
ed other than "natural" or items 23a or 28a-f show
e event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State Director Wicomico Delmar 1 Yes 2 No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Apt. 501 21875 800 East Chestnut Street U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14 Race - American Indian Armed Forces?
1 ☐ Yes 2 🛣 No Black, White, etc. 1 Never Married 2 Married 2 Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes Give 3 X Widowed 4 Divorced White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Garment Company Seamstress 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o ည Edward Allen Robbins Susan May Dunn 19a. Informant's Name/Relationship (Type, Pnint) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3716 Greenspring Road Havre de Grace, MD 21078 Joseph Allen Carr (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State any injury or St. Stephens CemeteryJan. 9, 2010 Delmar, Delaware 4 Donation 5 Other (Specify) 2. Name and Address of Facility
Short Funeral Home . Signature of Funeral Service Licenses 13 East Grove Street Towell Delmar, DE 23a. Part 1. Enter the disease, o compli shock, or heart failure. List only enter ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death ne cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Clostri Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) sician and burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Physician: The law requires that the death certificate be executed Due to (or as a consequence of): physician s the burial Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live Birth 2 ☐ Fetal deat
4 ☐ Pregnant at time of death
9 ☐ Unknown in the past 12 months? Month Dav Year signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by neumonitis 1 Yes 2 No 3 Probably 4 Unknown 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 1 Yes 2 No Yes Be (25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☑ No Other: ြုင 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Hospital or Attending Natural 5 Pending injury within 24 hours after death.

To the Funeral Director: Air completed filled in by the fu 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse, Practigner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the I within 2 only one 29b. Signature and title of 29c. License number HO059368 of person who completed cause of death (Item 23a) (Type, Print) 30. Name and add Salishung 100 CKVYELI 31. Date filed (Month, Day, Year) Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Baltimore.

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Rosalie C. Curran January 2010 45 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 6058 Avalon Drive Elkridge Howard 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth Birthplace (State or Foreign Country) Funeral 1 M 2 XF Months Days Hours Min 09/01/1944 Yrs Director 216-42-3584 65 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director must be notified 1 Tes 2 No MD Howard Elkridge 5 10e, Street and Numbe 10f. Zip Code 10g, Citizen of What Country? 23a Funeral 6058 Avalon Drive 21075 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. or þ 1 ☐ Yes 2 🔀 No If Yes, Give 1 Never Married 2 X Married 1 ☐ Yes 2 ₩ No Specify: White Specify: "natural" Completed 3 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. the 12 Computation Assistant Rouse Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Catherine Becker Peter P. Haspert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra Joseph L. Curran - husband 6058 Avalon Drive Elkridge, MD 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Crownsville Vet. Cem. 01/11/2010 Crownsville, MD 21. Signature of Funcial Service 22. Name and Address of Facility Harry H. Witzke's Family F.H.Inc. M00845 any ir 10 4112 Old Columbia Pike Ellicott City, MD 21043 Approximate Interval Between Onset and Death 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ UNG CANCER disease or condition resulting in death) monthy Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical death certificate be as the nse 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No for Month Day Year Pregnant at time of death 9 Unknown 9 Unknown á Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ HYPERTENSION, HYPERLIPIDENIA 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 performa 2 No certificate Yes 2 N 1 \sum Yes Hospital or Attending Physician: 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 N Residence 6 Other (Specify) Hospital 2 No 1 Tyes ျပ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending s after death. 1 ☐ Yes 2 ☐ No Investigation completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the Within 2 only one) 29b. Signature and title of certifie 29c. License number 138596 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

LOSEDH F. G.BBONS MA

31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

32. Fegistrar's Signature

8186 LANK BROWN RD, SWITEZOL, ELKRIDGE, MJ

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 01346 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2010 Anna Anita Cowaill Januaru 2:30a M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Sunrise Assisted Living Montgomery Silver Spring If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year
MAY 27, 1 7. Age (In vrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Months Country) Director 330-32-8912 Germany Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County with the Maryland 10c. City. Town or Location Director 10d. Inside City Limits 1 🗌 Yes 2 🗓 No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 11621 New Hampshire Avenue 20904 u.s.A. 72 hours after death 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 【 No Specify: If Yes, Give Year or Dates Completed 3 X Widowed 4 Divorced Specify: Caucasian the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working nd Mental Hygiene. marked other than "I matic event, the Med life. DO NOT use retired) Page 1 and 2 should be filed within iment of Health and Mental Hygiene. ant: If item 27 is marked other thar ury or other traumatic event, the M Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ပ Michael Prosniak Anna Ptasinska 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Audrey Anita Cowgill - Daughter 9314 Worth Avenue. Silver Spring, Maryland 20901 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Important: If it any injury or o 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Crematory: 01/06/2010 Brentwood, Maryland 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service License 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or c shock, or heart failure. List or amplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, by one cause on each line. Approximate Interval Between Onset and Death Years Immediate Cause (Final Physician Atherosclerotic Cardiovascular Disease disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions Examine Date to for as a consequence of, If any leading to immedia cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last signed by the attending physician and dedetached for use as the burial-trans Due to (or as a consequence of): Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 X No Day Year Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Hypertension 1 ☐ Yes 2 🏝 No 3 ☐ Probably 4 ☐ Unknown Congestive Heart Failure 24a. Was an 24b. Were autopsy findings available prior to completion of cause of Hospital or Attending Physician: The law After this certificate has autopsy death? Chronic Obstructive Pulmonary Disease 2 X No 1 Yes Yes **Division of Vital** 25. Was case referred to medical B 26. Place of Death (Check only one) examiner? Assisted Living Other: ပ္ 1 Tes 2 🛚 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work 2 Accident
3 Suicide
4 Homicide 1 🗌 Yes Investigation 24 hours after deatle Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifie 🔟 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check To the I within 2. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D53367 January 01, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shyamsundar Rajan. M.D 9801 Georgia Avenue, #117, Silver Spring, Maryland 20902 egistrar s Signatur State course Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Shella 0210 M Naomi Jan 3 12010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Columbia
Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Howard County General Hospital 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) Year) 1 □ M 2 🔀 F Months 217-64-6704 Director 54 08/01/1955 \mathbb{M} Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f school injury or other traumatic event, the Marinal Exercises 2000. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 □Yes 2X No MD Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7364 Oakland Mills Road Funeral 21046 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ ¥lo If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 📉 No þ Specify Black 3 Widowed 4 Divorced Specify: Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Disabled None 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert E. Coleman, Sr. ပ Mary Helen Dorsey 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah I. Coleman - sister 7364 Oakland Mills Road, Columbia, MD 21046 20a. Method of Disposition 20b. Place of Disposition (Name of permetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from 4 □ Donation 5 □ Other (Specify) Guzilford Mem. Park 01/09/10 Columbia, MD 21. Signatury of Funeral Service Lic 22. Name and Address of Facility Snowden Funeral Home 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease, or companies shock, or heart failure. List only of ications that caused the death. To not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death one cause on each line Immediate Cause (Final **Physician** Cerebral anoxia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Lardional monary arrest Sequentially list conditions, if any, leading to influentiate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence or) as the burial-trans pulminary embolism and resulting in death) Last Due to (or as a consequence of): Box 68760, attending physician for use as the buria 9 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery The law requires that the death 3 Ectopic pregnancy Day Year 5 ☐ Other (specify) P.O. | signed by the a 1 ☐Yes 2 ☑No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, þ Cardiomyopathy 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown icate has been si page 2 should t Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate consestive 1 ☐Yes 2 No 1 ☐ Yes or Attending Physiclan: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA After thi 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending death. investigation illed in by the f 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide within 24 hours a
To the Funeral C To the Hospital 29a, Certifier 11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Jau3,2010 100043662 2221 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BOYCE WILLAN Howard Lorax 31. Date filed (Month, Day, Year, 22. Registrar's Signature State

Registrar

JAN 06 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 01348 Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month Day Katherine Clark Jan. 2010 8:55 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1506 Leister Drive-Stewart House NH Silver Spring Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Month, Day, 1 □ M 2 🔀 F Months Hours Min Director 578-24-5003 June Usual Residence of Decedent show ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 🛛 Yes 2 🗌 No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 927 Gable Court 20901 United States Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🕱 No Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 African American If Yes, Give 1 ☐ Yes 2 X No Specify: "natural", Completed 3 Divorced 4 Divorced Specify: Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) unavailable Government Laundress Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) nd Mental H ည Marshall Jackson Hilda Walker Jackson should of Health and N item 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $\,20037$ Myrna Fawcett / Guardian 1730 24th Street NW Suite 15 Page 1 and 2 Washington, DC 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of h Important: If ite any injury or ot Date cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 DOther (Specify) Gate of Heaven Silver Spring, Md. 22. Name and Address of Facility 21. nature of Funeral Ser Stewart Funeral Home, Inc. 4001 Benning Rd. NE Washington, DC 20019 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Sersis Medical Due to (or as a consequence of): Examiner Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transi Cause (Disease or imjury the attending physician and that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 X No Pregnant at time of death 5 Other (specify) Month Day Year 9 Unknown 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 ☐ Yes 2 🕱 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b lirector, page 2 sl autopsy perform ☐ Yes 2X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 124 hours area on Euneral Director; A Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier x Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗌 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year)

State Registrar

DHMH 17 Rev 7/2009

D0060824

Silver Spring, MD 20904

01/04/2010

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Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

11161 New Hampshire Ave. Suite 305 Si

State of Maryland / Department of Health and Mental Hygienes State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year Physician 8:35 AM Alma Ella Chapman January 4 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince Georges Hospital Prince Georges Hyattsville 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 □ M 2 🔀 F 90 Director 578-46-7287 Oct. 18 1919 Germany Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 28a-f show r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1X Yes 2 No Director MD. Prince Georges Capitol Heights 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 510 Xenia Avenue 20743 US permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If them 27 is marked others any injury or others. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Completed by 1 ☐ Yes 2 🖾 No Specify. Specify: White 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Medical Secretary Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ျှ Arno Max Minna Alma Hille 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Ivy White / Granddaughter 7020 Oak Groove Way Elkridge, MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln 1/8/2010 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, MD. 21. Signature of Funeral Solute Licensee 22. Name and Address of Facility Fort Lincoln Funeral Home Marco 3401 Bladensburg Rd. Brentwood, MD. 20722 23a. art1. Enter the diagree, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical (or as a consequence of): Examiner Social flam list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine cate has been signed by the attending physician and page 2 should be detached for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 - Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Hospital or Attending 24 hours after death. 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) Type, Print) (Month, Day, Year) Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January 5, 2010 Year Prequita Raynell Chesley - Collier 11:26 am Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Southern Maryland Hospital Clinton Prince Georges Social Security Number 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days 1 M 2 XF 577-66-4525 61 01/12/1948 Washington, D. C. Director Usual Residence of Decedent shov 10a. State 10b. County ıral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Prince Georges Temple Hills 1 Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5216 Hagan Rd. 20748 United States 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc "natural", or 1 Never Married 21 Married þ 1 ☐ Yes 2 🛣 No If Yes, Give Maryland 21215-0036 1 ☐ Yes 21 No Specify: B1ack Specify: Completed 3 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) 12 Progran Analyst Private Industry other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Louis Nelson Saunders Audrey Minor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5216 Hagan Rd. Temple Hills, Md. 20748 <u>Lawrence Aaron Collier/ Spouse</u> Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State cemetery, crematory or other place injury or 4 Donation 5 Other (Specify) 1/15/2010 Lincoln Memorial Suitland, Md. 21. Signature of Funeral Service 22. Name and Address of Facility PPR&/P Alexander S. 5538 Mariboro Forestville, MD. 401085 20747 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician CAMINA disease or condition resulting in death) Medical Due to (or as a consequence of) Examine Sequentially list conditions, it any, leaving to immediate cause. Enter Underlying Examine nding physician and use as the burial-transit To the Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ atter in the past 12 months?
1 Yes 2 No ò Month Pregnant at time of death been signed by the s should be detached 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy death? certificate 1 Yes 2 X No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 은 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify, this within 24 hours after death.

To the Funeral Director, After thi completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending injury 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 \square Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of ce 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Date filed (Month, Day, Year JAN 0 8 2010

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month January Bay 2010 Bob Dean Carroll 3:11 a M Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Callaway St. Mary's Hospice House 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 1X M 2 □ F 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 08/10/1928 Country) Tennesse Director 411-64-0449 81 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo 27 is marked other than "natural", or items 23a or 28a-f s traumatic event, the Medical Examiner must be notified Maryland St. Mary's Mechanicsville 1 🗌 Yes 2 🛣 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 40390 Beach Drive 20659 United States Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian Armed Forces Black, White, etc. þ 1 Never Married 2 X Married 2 XNo Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: If Yes, Give White Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) <u>Electrical Foreman</u> Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Thomas J. Carroll Mary Sells 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mildred Carroll/Wife item 27 40390 Beach Drive, Mechanicsville, MD 20659 Department of Health Important: If item 27 any injury or other tr 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Jaffuary 1 X Burial 2 Cremation 3 Removal from State Charles Memorial Gardens 14, 2010 Donation 5 🗆 Other (Specify) Leonardtown, MD 21. Sign trure of 22 Name and Address of Facility Brinsfield-Echols Funeral Home, P.A. M00817 30195 Three Notch Rd., Charlotte Hall, MD 20622 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Divido for sala consecucione d'il Exami attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Day Yes 2 No signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hospital or Attending Physician: The law requires t 24 hours after death.
Funeral Director: After this certificate has been sign 1 Yes 2 No 3 Probably 4 Unknown Completed completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No Yes 2 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospice Hospital 2**X** No 1 Yes မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6XXOther (Spec 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 1 Natural 28c. Injury at work? 28d. Describe how injury occurred injury 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and titl 5575 person who completed cause of death (Item 23a) (Type, Print)

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DHMH 17 Rev 7/2009

State Registrar 30. Name and addre

Dr

Year)

31. Date filed (Month, Day,

MD 20650

dennifer Schmidt, Leonardtown,

State of Maryland / Department of Health and Mental Hygiene 2 U | U For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 3. 2<u>010</u> Physician/ Month 8 2:08 a.M Donald Crver January Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 41021 Cryer Court Leonardtown St. Mary's If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland Social Security Number **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth Days Min. 01/10/1937 1 X M 2 □ F Director 213-34-5276 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland St. Mary's Leonardtown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 41021 Cryer Court 20650 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🎇 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 0. Completed by 1 Never Married 2 X Married 1 Yes Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", 3 Divorced 4 Divorced Specify: Year or Dates White permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation. 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Farmer Farming Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas Leonard Cryer, Sr. Mary Grace Stone 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret E. Cryer/Wife 41021 Cryer Court, Leonardtown, MD 20650 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lady's Cemetery 01/12/2010 Leonardtown, Maryland 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signature Juneral Service Lansee
Edward N. Brinsfield, 22955 Hollywood Road, Leonardtown, MD M00052 20650 Jr. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on ach line Immediate Cause (Final Onset and Death Pnysician disease or condition Medical resulting in death) Due to (or as a con equence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence on To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death
Unknown 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Dres 2 No 3 Probably 4 Unknown cate has been sig page 2 should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perforn 1 Yes 2 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 **1** No 1 🗌 Yes ဂ္ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 1 Yes 2 No 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b, Signature and title of certifier HOU 5575 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jennifer Schmidt, 40900 Merchants Lane, Suite 205, Leonardtown, 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2010 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Mahuary Day Earl Eugene Corum Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Frederick Memorial Hospital Frederick Social Security Number 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, Days 1 🛛 M 2 🗆 F Min. Director 234-20-1424 88 May Usual Residence of Decedent 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. sant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at Director Maryland Frederick Walkersville 10e. Street and Number 10g. Citizen of What Country? 12 Glade Court 21793 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 🖾 Yes 2 🗌 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Completed 3 N Widowed 4 Divorced Year or Dates. WWII the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) College Professor State University Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edgar Corum Hazel Sebastian 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wilma J. Polce / Daughter Glade Court Walkersville, Maryland 21793 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 s
Department of IImportant: If ite
any injury or ot 1 Burial 2 X Cremation 3 Removal from State January 4 Donation 5 Other (Specify) Stauffer Crematory Frederick, Maryland 4, 2010 21. Signature of Funeral-Service Licensee 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) precenonia Medical Due to (or as a consequence of Examiner bowel obstrust on Small Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) physician and s the burial-transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Box 68760 signed by the attending place as the detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Ribinio tion Records, page 2 should Hypertension 24a. Was an autopsy perform anemia Yes or Attending Physician: completed filled in by the funeral director, of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2**X** No 1 Yes Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at Natural 5 Pending injury Division s after death. 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide determined City or Town, State) To the Hospital within 24 hours a To the Funeral C Medical 29a. Certifier (Check

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Frederick, Maryland 21702 Approximate Interval Between Onset and Death Dougs 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 2 No 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) mo 21702

2010

Black, White, etc

White

2:45

9. Birthplace (State or Foreign

West Virginia

10d. Inside City Limits

1 X Yes 2 No

Frederick

Рм

State Registrar DHMH 17 Rev 7/2009

only one 29b. Signa

Date filed (Month, Day

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hiren N Thah, M.D. Thomas

Registra

10-00041	
John Clark	(

John Clark	State of Maryland / Department of Health and Mental Hygiene **Certificate of Death**	2010 0135
Physician/	Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Decedent's Name (First, Middle, Last)	o. Time of Boats
Medical Examiner	John Aldon Clark January	2, 2010 Year 1751 hrs
	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 10 Glenn Creek Circle Elkton	4c. County of Death Cecil
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of 8	Birth(MM/DD/YYYY) 9. Birthplace (State or
Director	410-72-4370 1X M 2 F 62 Yrs. Months Days Hours Min. June	3, 1947 Foreign Country) TN
ž.	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
. E. a.	ND C 11	1 Yes 2 No
the Maryland a or 28a-f sh tiffed at once	MD Cecil Elkton 10e. Street and Number 10f. Zip Code	10g. Citizen of What Country?
the M	10D Glenn Creek Circle 21921	USA
5-0036 ed within 72 hours after death with the Maryland fygiene. other than "natural", or items 23a or 28a-f show any the Medical Examiner must be notified at once. Completed by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or Named Forces? 14. Never Married 2 Married 2 Armed Forces? 15. Was Decedent of Hispanic Origin? (Specify Yes or Named Forces)	
er deat , or its	1 Never Married 2 Married 1 X Yes 2 No 1 Yes, specify Cuban, Mexican, Puerto Rican, etc.) 3 Widowed 4 X Divorced If Yes, Give Year 1 0.6.6.77.	
urs afte tural" amine	or Dates: 1900-74	Specify: Black 16b. Kind of Business/Industry
5-0036 ed within 72 hour object than "natur he Medical Exam Completed	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life, DO NOT use retired)	
within within iene.	5+ Business Manager	Business
215-1 be filed ntal Hyg rked oth ent, the		•
212 ould bo the Ment mark it even To E		
MD vd 2 sh ulth and m 27 is aumat	Kimberly Clark/ daughter 1131 Washington St. Macon,	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygeine. Important: If item 37 is marked other than "matural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Method of Disposition (Name of cemetery, crematory or other place) 20d. Place of Disposition (Name of cemetery, crematory or other place)	20c. Location - City or Town, State
timent report of the contract	4 Donation 5 Other Specify. R.T. Foard Funeral Home, P.A. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility	Rising Sun, MD
Ba perm Depa Imper injur	R.T. Foard and Gee	ND 01001
Physician	23a, Part I) Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respirator a failure. List only one cause on each life.	rrest, shock, or heart Approximate Interval Between Onset and
Medical Examiner	Immediate Cause (Final disease a Almerosclerotic Cardiovascular Disease	Death
	or condition resulting in death) Due to (or as a consequence of):	
ner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause	
ted d ansit Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	
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0, e be execut ysician and burial - tra	UNPENDED	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transiedical Certification: To Be Completed by Physician/Medical E	23b. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy	23d. Date of delivery Month Day Year
, P.O. Box 6876 res that the death certificat signed by the attending phote detached for use as the by Physician/M	4 Pregnant at time of 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown	V.
O. Bont the destruction by the arched for Physics	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did	tobacco use contribute to the cause of death?
Division of Vital Records, P.O. Ital or Attending Physician: The law requires that th rs after death. a) Director: After this certificate has been signed by led in by the funeral director, page 2 should be detact errification: To Be Completed by Pertification: To Be Completed by P	Diabetes Mellitus 1 7	es 2 No 3 Probably 4 🗸 Unknown
n of Vital Records, ling Physician: The law required the this certificate has been stringed director, page 2 should on: To Be Completed	24a. Wa auto	ppsy prior to completion of cause of
Recorder The la	1 ✓ Yes	ormed? death? 2 No 1 ✓ Yes 2 No
tal Recition: The certificate rector, page	25. Was case referred to medical 26.Place of Death (Check only one)	
ing Physi ing Physi After this uneral dii	7 More of Details 22 No 22 Details and 122 Det	Residence 6 🗸 Other: Scene
on cending ath. or: Af or: Af tun	1 V Natural 5 Pending (Month, Day,Year)	
Division o within 24 hours after death. To the Funeral Director: After completely filled in by the funeral edical Certification:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location or Town,	(Street and Number or Rural Route Number, City State)
Dispital hours ineral y filled		
To the Hospital within 24 hours To the Euneral completely filled	Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cau (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date	
To wit Con	and manner stated. 29b. Signature and title of certifier 29c. License number	29d Date signed (Month, Day, Year)
	(M) (O.C.M.E.	January 5, 2010
2+IVA	30. Name and address of person who completed cause of death (Item 23a)	
State	Russell Alexander MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature	
Registrar		

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 1700 P M Ralph Emmett Dant January 2010 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Cecil 49 Dant Lane E1kton 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours Min. 1 X M 2 □ F March 21, 1921 313-16-0562 88 Indiana Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 X No E1kton Maryland Ceci1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21921 49 Dant Lane United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status 12. Was Decedent Ever in U.S. Was Deceut. Armed Forces? 1 □Yes 2 📉 No 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify: Specify: 3 X Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) e, Zip Code)

29d. Date signed (Month, Day, Year)

10

Physician /Medical For State Registrar

10a, State

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

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Completed

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Pages 1 and 2 should be filed within 72 hours after death with the Marylanc

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ire Medical Examiner must be notified at

Examiner Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Physician/Medical

s been signed by the should be detached icate has I , page 2 s certificate : After this certific funeral director, n 24 hours after death.

• Funeral Director: A

pletely filled in by the fu death.

Division of Vital Records, P.O. Box 68760,

þ Completed Be Certification: To Medical

(Check only one)

29b. Signature and title of certifier

Carlo E. Gopez,

31. Date filed (Month, Day, Year)

29a. Certifier

Elementary/Secondary (0-12)	College (1-4or 5+)	Railroad Ca	, r Distribu	tor R	ailroad	
17. Father's Name (First, Middle, La	st)	Natificat ca		(First, Middle, Maiden		
Francis Logan D	ant		Mable R	iggins		
19a. Informant's Name/Relationship		19b. Mailing Address (Street			or Town, State, Zip (Code)
Mark E. Dant/So	n	49 Dant Lane,	Elkton, M	D 21921		
20a. Method of Disposition 1 A Burial 2 Cremation 3 4 Donation 5 Other (Spe	☐ Removal from State	Place of Disposition (Name of emetery, crematory or other pla Saints Cemete	ce) Janua	ry 20c. Lo	ocation - City or Tow	
21. Signalure of Funeral Service Lic 23a. Part1. Enter the disease, or co	sensee	22. Name and Addre Hicks Home 103 W. Sto	ess of Facility for Funer ackton Stre	als, P.A. et, Elktor	n, MD 219	
shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a consequ	cular Dystro	phy			Onset and Death
Sequentially list conditions, if ause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1	I death 3 Ectopic pregnand	sy		23d. Date of deliver Month E	ry Day Year
Part II. Other significant conditions	s contributing to death but not rest	ulting in the underlying cause giv	ven in Part I.		use contribute to the	e cause of death?
				24a. Was an autopsy performed?	prior to com death?	sy findings available ipletion of cause of
25. Was case referred to medical examiner?			26. Place of Death	·		
1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 ☐ DOA Oth	ner: 4 ☐ Nursing Hom	e 5 Residence	6 🕅 Other (Specify)	Son's Residence
27. Manner of Death 1 Natural 5 Pending 2 Accident Investigat		28b. Time of Injury Mon	ry at 24 k? IYes 2 □ No	8d. Describe how inju	y occurred	.coracnee
3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		ome, farm, street, factory, office	21	8f. Location (Street ar City or Town, State	nd Number or Rural	Route Number,

Registrar DHMH 17 Rev 1/2001

State

completely

within 2

138 Cathedral Street, Elkton, MD

and manner stated

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

🖫 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

65902

21921

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			Decedent's Name (First, Middle, Last)					2. Date of Deat Month		Year	3. Time of Death
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	Examin	er	4a. Facility Name (If not institution, give street and number	(r)			Location of Death		4c. County		*aal.
e# .	F		Laurel Regional Hospital 5. Social Security Number 6. Sex 7.	Age (In yrs. last i	birthdav)	If Under 1 Year	Laurel If Under 24 Hrs.	8. Date of Birth	Prince	9 Rirthn	lace (State or Foreign
	Funeral Director		579-84-7658 1 ☑ M 2 ☐ F Usual Residence of Decedent	78	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day 02/10/1	1931	El S	alvador
	ryland show	_	10a. State 10b. County	10c. City, To	own or Loc	cation			<u>-</u> -	1	Od. Inside City Limits
	Ba-f s	Director	Maryland Prince George's				Beltsvill				1 ☐ Yes 2 No
	with the		10e. Street and Number			10f. Zip Code	2000	1	0g. Citizen of W		
	ns 23	Funeral	4603 Naples Avenue 11. Marital Status 12. Was Deceder	nt Ever in U.S.	13. V		20705 spanic Origin? (Spin, Mexican, Puerto	ecify Yes or No-	14. Race	U.S.	A • an Indian,
020	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hyglene. Item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Health Examinar must be rediffed at	by Fur	Armed Force 1 Never Married 2 Married 1 Yes 2 If Yes, Give 3 Widowed 4 Divorced Year or Date:	s? ☑ No		fYes, specify Cuba Mayes 2 No	n', Mexican', Puerto Spec <i>ify:</i> Salv		Black	k, White, e	
5	72 hour natural	Completed I	15. Decedent's Education (Specify only highest grade completed)			lent's Usual Occupa			16b. Kind of Bu	siness/Ind	
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<u> </u>	2 should and Mer Is marke aumatic	Ĕ	19a. Informant's Name/Relationship (Type. Print)		9b. Mailin	g Address (Street a	and Number or Run				Code)
Ě	1 and 2: Health a tem 27 Is		Maria Dominguez - Spouse				venue, Be	ltsville	e, Maryl	2and	20705
ב כ	of He If iten		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from Sta	20b. Place ceme	e of Dispos etery, crem	sition (Name of natory or other plac	e) [Date	20c. Location -	City or To	wn, State
altillion	Pag tment tant: jury c		4 Donation 5 DOther (Specify)		e wa	shington	Cem: 01/0:	7/2010	Adelphi	, Ma	ryland
0	permit. Pages 1 and Department of Heal Important: If item 2 any Injury or other ODCs.		21. Signature of Funeral Service Licensee	- 00							Home, Inc.
	45= 4	_	23a. Part 1. Enter the disease, or complications that caus	sed the death D						sprin	g, MD 2090
	Dhysisian		shock, or heart failure. List only one cause on each	line.		-,	9,		,		Interval Between Onset and Death
-,	Physician /Medical		disease or conditiona. Septu	c Shock as a consequence	ce of):						
	Examiner		Sequentially list conditions b. Acute	Respiro	itory	Failure					
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<u> </u>	n: Th ficate r, pag								2 No 1	death? I □ Yes	2 □No
5	s certi irecto	Be c	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No Hospital: 1 ☒ Inpa	atient 2 ER/	Outpation	t 3 DOA Othe	26. Place of Deat	h <i>(Check only or</i> ome 5 ☐ Resid		or (Cit	- A
5	g Phy er this eral d	n: To	27. Manner of Death 28a. Date of I	· · · · · · · · · · · · · · · · · · ·	b. Time of Injury		y at	28d. Describe h			y/
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	e Hospit 24 hour le Funera eletely fille	Medical (29a. Certifier (Check only one) 1	s of examination							
	withir comp	ğ	29b. Signature and title of certifier			29c. License		2	29d. Date signed		
•	5		30. Name and address of person who completed cause of	f death (Item 23	a) (Type		67210		1 9	201	
			Konit Kniesos 400 W	lest 7th	Str	ret. Fred	lerick, Ma	aryland	21701		
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Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760 👉

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		For State		State	of Mar	yland		partmei ertificat		lealth and I Death	Mental Hy	_			
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Examin	er	4a. Facility Name (if								Location of Death		1	. County o		1
Funeral		Southern 5. Social Security No		6. Sex	7. Age (II	n yrs. las	st birthda	y) If Un d e	nton er 1 Year	If Under 24 Hrs.	8. Date of Bir	th		9. Birthp	rge s
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and show d at	tor	10a. State	10b. County		16	0c. City,	Town or	Location						10	Od. Inside City Limits
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death v items ier mu	Funeral	11. Marital Status	iring Dr.	12. Was Dece Armed Fo		r in U.S.	1	3. Was Dece	dent of Hi	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No-		14. Race		
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amportant: If item 27 is marked other than "natural", or items 23a or 28a-f show amportant: If item 27 is marked other than "natural", or items 23a or 28a-f show amportant it items 27 is marked or other traumatic event, the Medical Examiner must be notified at once.	by	1 Never Marri 3 X Widowed		ed 1 \(\superset\) Yes If Yes, Giv	2 ⊠ No ∕e)			-	Specify:	Tricali, Cic.,		Specify:	, White, e	
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Page 1 nent or ant: If i		1 🔀 Burial 2 4 🗌 Donation		3 ☐ Removal from pecify)				rematory or Ceme			08/2010	Jac	kson	ville	e, FL
permit. Departr Imports any inju		21. Signature of Jul	neral Service Li	censee	9	71	7	22. Name a	nd A dd res	ss of Facility Ma	rshall'	s Fu	inera	1 Hor	
ED = 60		23a Fart 1, Enter t	the disease, or	complications that	caused th	ie death.	. Do not e			t NW Was			2001	1	Approximate
Physician/		shock, or hear Immediate Cause (disease or condition	rt failure. List o (Final	nly one cause on ea	ch line.		P	10	San	Acc	the	22	,		Interval Between Onset and Death
Medical Examiner		resulting in death)	1	Due to	(or as a c	onseque	ence of):	.,						\top	
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equires een sig ould b											1 🗆	Yes 2	□ No 3	3 🗌 Prob	oably 4 Unknown
has be	Completed										24a. Was auto perfe		pr	ere autop ior to coreath?	osy findings available inpletion of cause of
sician: The lav certificate havirector, page 2	Be Co	25. Was case referre	ed to medical						26. Pla	ace of Death (Chec	1 🗌 Yes		1	☐ Yes	2 🗌 No
Physicia this cer ral direct	To B	examiner?		Hospital:	Inpatient	2 X	R/Outpa	tient 3 🗆 🗆		ari	ome 5 🗆 Resi	dence (6 🗌 Other	(Specify)	
ding P. h. After ti funera	sate:	27. Manner of Death	5 Pending	9	of injury th, Day, Y		28b. Time injur		28c. Injury work		28d. Describe	how injui	ry occurred	d	
Atten er deat ector: by the	Certificate:	2 Accident 3 Suicide 4 Homicide	Investig 6	ot be 28e. Place	of Injury		ne, farm,	street, factor		100 2 2 110				or Rural	Route Number,
oital or urs aft eral Dir illed in			N								City or Tov				
To the Hospital or Attending Is within 24 hours after death. To the Funeral Director: After completed filled in by the funer	Medical	(Check 2	Medical E	Physician: To the base caminer on the base Nurse Practioner:	sis of exam	mination.	and/or inv	vestigation, in	my opinio	on, death occurred a	at the time, date	and place	e, and due	to the cau	ise(s) and manner stated
To th To th	_	29b. Signature and		111	//				c. License	number			ate signed		
Le		30. Name and add	/nd	ud 6	No of the state	the /lt own /	220) /5:=	o Print\	DS	53209		1-7	2-10	<u> </u>	
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10-00055

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1- For State Certifica	te of Death	Re	eg. No. 201	11 11 13
Physicia al Examin	n/	Decedent's Name (First, Middle,Last)		Date of Deat Month	h 2010ear	3. Time of Death
ai Exami		Joseph Anthony Dickson 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Deat	January 3,	4c. County of Deat	0712 hrs
		775 Ragan Road	Conowingo		Cecil	"
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birtho	day) If Under 1 Year If Under 24Hr Months Days Hours Mil		th(MM/DD/YYYY) 9. Bii Co	rthplace (State or Foreign ountry) MD
any	F	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location			Land Inside Objet Limite
≱		Joseph Company				10d. Inside City Limit 1 Yes 2 N
Aaryland 28a-f show I at once	Director	MD Worcester Berling 10e. Street and Number	10f, Zip Code	10	ng. Citizen of What Cou	
th the Maryland 23a nr 28a-f sho nntfiled at once.		10943 Pitts Rd.	21811		USA	
5 - 4	Funeral	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No	 Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerto 		14. Race - Amer White, etc.	ican Indian, Black,
s after	<u>``</u>	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 Yes 2 No specify:			ite
2 hour	eted		ecedent's Usual Occupation (Give kind of iring most of working life, DO NOT use re		16b. Kind of Business/	Industry
Hygiene. other than the Medical	Comple		umber		Plumbin	a
Hygien to the Me		17. Father's Name (First, Middle, Last)		e (First, Middle, M		9
should be filed vand Mental Hygins and Mental Hygins is marked oth	B B	John Milton Dickson 19a. Informant's Name/Relationship (Type, Print) 19b. 1		e Hadder		
2 shoul and N	٩	1,427	Mailing Address (Street and Number or D943 Pitts Rd., Ber			e, Zip Code)
I and 2 s Health ar item 27		20a. Method of Disposition 20b. Place of I	Disposition (Name of cemetery,	Date	20c. Location - City or	Town, State
Pages ent of nt: If	- 1		y or other place) Ceen Cemetery 1/	6/2010	Berlin, M	D
permit. Pages 1 and 2 s Department of Health a Important: If item 27 injury or other traum		21. Signature of Fundal Service Licensee			uneral Hom	
	-1	M. Jul Duriele	108 William St.	Berlin.	MD 21811	
ysician	- 1	23a. Part I. Enter the disease, or complications that caused the death. Do not efailure. List only one cause on each one.	enter the mode of dying, such as cardiac	or respiratory arre	st shock or heart	Approximate Interv
Medical	- 1			or respiratory are	or, orroom, or mount	Between Onset an
		Immediate Cause (Final disease a. Hypertensive Atherosclerotic C	Cardiovascular Disease	or respiratory arre	or, orrestr, or mean	
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hours after death. The law requires that the death certificate be executed the hours after death. The control of After this certificate has been signed by the attending physician and y filled in by the funeral director, page 2 should be detached for use as the burial - transit	edical Ceruncation: 10 Be Completed by Physician/Medical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Eriter Underlying Cause (Disease or injury that initiated events resulting in death) Last UNPENDED FEMALE: 30. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions Diabetes mellitus Diabetes mellitus Hospital: 1 Inpatient 2 ER/Outp (Month, Day, Year) Part II. Natural 5 Pending Investigation 3 Suicide 6 Could not be determined (Specify) 19a. Certifier Check only 2 Medical Examiner: On the basis of examination and/or invested and manner stated.	Fetal death 3 Ectopic pregnation of the underlying cause given in Part I. 26. Place of Death (Check patient 3 DOA Other, 4 Nursing and of Injury 28c. Injury at Work? 1 Yes 2 No on, street, factory, office building, etc.	ancy 23e. Did tot 1 Yes 24a. Was a autops perforr 1 Yes 2 only one) ng Home 5 F 28d. Describe he 28f. Location (St or Town, Sta	23d. Date of delivery Month Dacco use contribute to 2 No 3 Prot prior to a death? 1 Ye Residence 6 Other ow injury occurred treet and Number or Ruate) (s) and manner as statund place, and due to the	Between Onset and Death The cause of death? Death The c
In the death certificate be executed The law requires that the death The death The this certificate has been signed by the attending physician and y filled in by the funeral director, page 2 should be detached for use as the burial - transit	Medical Certification: 10 be completed by Physician/Medical Examiner	Amended to Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Eriter Underlying Cause (Disease or injury that initiated events resulting in death) Last UNPENDED FEMALE: 3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions Diabetes mellitus Diabetes mellitus Amended Permined 23c. If yes, outcome of pregnancy 1 Live birth 2 Pregnant at time of death 5 9 Unknown Contributing to death but not resulting in contributing to death but not resulting in livestigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm (Specify) 29b. Signature and title of certifier and manner stated. Natural of Death Medical Examiner: On the basis of examination and/or investigation and manner stated.	Fetal death 3 Ectopic pregnation of the underlying cause given in Part I. 26.Place of Death (Check patient 3 DOA Other 4 Nursing the of Injury 28c. Injury at Work? 1 Yes 2 No occurred at the time, date and place, and estigation, in my opinion, death occurred at 29c. License number O.C.M.E.	ancy 23e. Did tot 1 Yes 24a. Was a autops perforr 1 Yes 2 only one) 1 Zed. Describe his 28f. Location (Stor Town, Stort Town, Stort Course at the time, date a	23d. Date of deliver Month I Month I Daacco use contribute to 2 No 3 Protein 24b. Were au prior to death? 1 Yew No 1 Yew No 1 Yew Other Owningury occurred treet and Number or Ruate)	Between Onset and Death Year the cause of death? bably 4 V Unknown tropsy findings availably completion of cause of es 2 No r: Scene
In the death certificate be executed The law requires that the death The death The this certificate has been signed by the attending physician and y filled in by the funeral director, page 2 should be detached for use as the burial - transit	medical Certification: 10 Be Completed by Physician/Medical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Eriter Underlying Cause (Disease or injury that initiated events resulting in death) Last UNPENDED FEMALE: 3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions Diabetes mellitus Diabetes mellitus Hospital: 1 Inpatient 2 ER/Outp (Month, Day, Year) Tyes 2 No Investigation Suicide 6 Could not be determined (Specify) 9a. Certifier 1 Certifying Physician: To the best of my knowledge, death and manner stated.	Fetal death 3 Ectopic pregnation of the underlying cause given in Part I. 26.Place of Death (Check patient 3 DOA Other 4 Nursing the of Injury 28c. Injury at Work? 1 Yes 2 No occurred at the time, date and place, and estigation, in my opinion, death occurred at 29c. License number O.C.M.E.	ancy 23e. Did tot 1 Yes 24a. Was a autops perforr 1 Yes 2 only one) 1 Zed. Describe his 28f. Location (Stor Town, Stort Town, Stort Course at the time, date a	23d. Date of deliver Month I Month I Daacco use contribute to 2 No 3 Protein 24b. Were au prior to death? 1 Yew No 1 Yew No 1 Yew Other Owningury occurred treet and Number or Ruate)	Between Onset and Death Year the cause of death? bably 4 V Unknown tropsy findings availably completion of cause of es 2 No r: Scene

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Dea **Physician** 2010 Daisy Thompson DuBree Jan 06:40a M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Ceci1 Calvert Manor Nursing Home Rising Sun If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 2/25/1922 **Funeral** Social Security Number 6. Sex Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Min 1 □ M 2 🖵 F Director 201-03-0168 PA Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show Examine rount be notified at 1 ☐ Yes 2 🔀 No Director Rising Sun MD Cecil 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21911 USA 1115 Ridge Rd. by Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 ∏ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☑ No Specify: White 3 ₩ Widowed 4 □ Divorced Completed 7 is marked other than "nature traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank M. Burns Hannah McGuirk ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health a
Important: If item 27 is
any Injury or other trau Ronald Thompson/ son 1115 Ridge Rd. Rising Sun, MD 21911 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Slate Ridge Cemetery: 1/8/2010 4 ☐ Donation 5 ☐ Other (Specify) Delta, PA 22. Name and Address of Facility
R.T. Foard Funeral Home, 21. Signature of Funeral Service Lice S. Queen St. Rising Sun, MD 21911 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one oal on each line. Approximate Interval Between Onset and Death Immediate Cause inal disease or condi in resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): or Attending Physician: The law equires that the death certificate be executed burial-transit and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Physician/Medical the attending pl IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death
☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Year 5 ☐ Other (specify) certificate has been signed by the rector, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>Ş</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 200 After this certification, I 25. Was case referred to medical examiner? æ 26. Place of Death (Check only one) 1 ☐ Yes 2 🗷 👊 Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural
2 Accident Jospital c.
4 hours after dec.
7.meral Director: After 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

State Registrar 29b. Signature an

31. Date filed (Month, Day, Year)

tle of certifier

Name and address of person who completed cause of death (Item 23a) (Type,

MD

Registrar's Signature

29c. License number

29d. Date signed (Mgnth, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month **Physician** 2010 MOSEN January ma /Medical 4c. County of Death 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) **Examiner** town Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day) 7. Age (In yrs. last birthday) 6. Sex Social Security Number **Funeral** Days 1 □ M 2 😡 F 1944 Texas 65 Dec 219-42-8341 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County ed other than "natural", or items 23a or 28a-f show event, the involved Experience and one notified at 1 Yes 2 No **Funeral Director** Kennedyville MD Kent 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 28040 Creamery 21645 st. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black White etc 1 ☐Yes 2 No If Yes, Give ty Never Married 2 ☐ Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify. Completed by 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) I Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) <u>Health Department</u> Registered Nurse 5+ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: If Item 27 is marked oth any injury or other traumatic event once. Be Gwendolyn Lance Robert N. Dempsey ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Chester, PA. 19013 2407 Green St. James D. Dempsey (brother) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Kennedyville Cem. 1/20/2010 Kennedyville, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signa of F ner l ervice 22. Name and Address of Facility
alena Funeral Home of Stephen L Schaech M00510 118 West Cross St. Galena, MD. 21635 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or her it failure. List only one cause on each line. Immediate Calise (Final disease or condition resulting in death) **Physician** Cardio Phimonary /Medical Due to (or as a consequence of): **Examiner** polenho Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or consequence of): Examine Staphalococcal Sepsis burial-transi scleencied P.O. Box 68760, physician the burial Physician/Medical 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 🗷 No 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed ! Division of Vital Records. 2 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown acidosis Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Kenal Discay autopsy performed? 1 □ Yes 2 🗷 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1∐Yes 2⊠No 1 MInpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? After the Hospital or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) after 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 DOO 69457 cause or death (Item 23a) (Type, Print) Center, Chester town, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Kalakurth

State Registrar 31. Date filed (Month, Day, Year)

2010

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death JAN. 17, 2010 **Physician** MARGY LOU DILLMAN 7:10P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** CIVISTA MEDICAL CENTER LA PLATA CHARLES If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day Year) 2 - 24 - 1946 5. Social Security Number 9. Birthplace (State or Foreign Country)
WASH D.C 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 ▼ F 63 217-44-5161 Director Usual Residence of Decedent Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits r items 23a or 28a-f show instrumt te notified at MD. CHARLES Director BRYANTOWN 1 ☐ Yes 2 X No the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 12870 EDELEN ROAD U.S.A. 20617 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 [X]No If Yes, Give Ye ar or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 ō Exam 1 ☐Yes 2🌠 No Specify: Specify: WHITE þ 3 Widowed 4 Divorced "natural" tal Hygiene. d other than "natura event, Ille Medical E Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) P.G.CO.SCHOOLS SCHOOL BUS DRIVER traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be of Health and Mental I JOSEPH E. JOHNSTON LUCILLE VIRGINIA BURNS ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARGARET FRANCESCO-DAUGHTER 10832 CAVERLY CT. HUNTERSVILLE, N.C. 28078 20b. Place of Disposition (Name of cemetery, crematory or other p. 20a. Method of Disposition Date 20c. Location - City or Town, State ŏ ö 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State INITY MEM • GARDENS
4 ☐ Donation 5 ☐ Other (Specify) Department of Important: If any Injury or once. 1-21-201 QWALDORF, MD. MOQ479 21. Signature of Funeral Service Licenses 22. Name and Address of Facility RAYMOND FUNÉRAL SERVICE, P.A. LA PLATA, MARYLAND 20646 Juho 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) pronic /Medical Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 Other (specify) ed by the 9 Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, been signe should be 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has lirector, page 2 s autopsy performe 2+7No 2 TO No 1 ☐ Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 11 Inpatient ၉ 2 ER/Outpatient 3 DOA this To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After t completely filled in by the funera 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred Division 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 145737

DHMH 17 Rev 1/2001

State Registrar 3328 OLD WASH.RD. WALDORF, MD. 20602

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR.N.JAYANTHAN, MD

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Adrianna Alicia DuBois State of Maryland / Department of Health and Mental Hygiene 2010 01362 1- For State Certificate of Death Registrar Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month **Medical Examiner** Adrianna 0341 hrs Alicia DuBois January 13, 2010 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death c. County of Death Laurel Regional Hospital Prince George's 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8 Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** oreign US Virgin Is Hours Director 580-17-1165 9/25/1979 2 X F 1 M Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Prince George's 1 Yes 2XX No is marked other than "natural", or items 23a or 28a-f show atte event, the Medical Ex. miner must be notified at once. Maryland Laure1 Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11401 Laurel Walk Way USA 20708 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. 1xxxNever Married 2 Married Yes 2XX No If Yes, Give Year Biracial 3 Widowed Divorced 1 Yes 2 XX No specify: Specify: ठ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) than 1 and 2 should be filed within Health and Mental Hygiene. 12 years Secretary Law Office 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Ardron DuBois Be Penny Maxie 19a. Informant's Name/Relationship (Type, Print) ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8625 Greenbelt Rd. # T-4 Greenbelt, Maryland Penny Maxie / Mother If item 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State timore, crematory or other place) Pages 1 1 X Burial 2 Cremation 3 Removal from State of RIVERDALE BAP. CHURCH 1/18/2010 UPPER MARLBORO, MD. Dopation 5 Other Specify 21. Signature of Funeral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home P.A. 6160 Oxon Hill Road Oxon Hill, Maryland ala 23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Approximate Interval Between Onset and /Medical Death Methadone intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical **X** UNPENDED AMENDED e attending physician for use as the burial g899 1/25/10 TT 23a,27,28a-f, perME, The law requires that the death certificate be Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 2 Fetal death Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 ✓ Unknown g Unknown the a signed by the betache Part II. Other significant conditions contributing to death but not resulting in the uncerlying cause given in Part I. 23a. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed certificate has been 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? 1 🗸 Yes ✓ Yes 2 No 25. Was case referred to medical the Hospital or Attending Physician: 26. Place of Death (Check only one) Be Other₄ Hospital: 1 Inpatient 2 ✔ ER/Outpatient 3 Nursing Home 5 Residence 6 Other: After this 1 Yes 27. Manner of Death 28a Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural death. 5 Pending FD 1/13/10 Fd 2:52 am 1 Yes 2X No Director: I in by the f Accident Investigation 28f. Location (Street.and Number or Rural Route Number, City or Town, State 11401 Laure Walk Dr Laure 1, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc hours after 3 6 X Could not be Suicide found in residence within 24 hours a To the Funeral I determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical one) 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d Date signed (Month, Day, Year) O.C.M.E. nal January 13, 2010 du 30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) State JAN 21 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) Day **ESTRADA** GLORIA BEATRIZ **Physician** 05, 2010 JAN. 9:10AM M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PRINCE GEORGE'S FORT WASHINGTON 2027 TINKER DRIVE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 50 1 □ M 2 🖾 F 215-29-8710 07-14-1959 PERU Director Usual Residence of Decedent 10d, Inside City Limits 10b. County 10c. City, Town or Location 10a, State 28a-f show other traumatic event, the Medical Examiner must be notified at PRINCE GEORGE'S FORT WASHINGTON MD1 □ Yes 2 📆 💥 🖔 Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ò 20744 PERU 2027 TINKER DRIVE or items 23a Funeral within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2000 No If Yes, Give 14. Race - American Indian, 11. Marital Status Black, White, etc. Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: PERUVIAN XIXYes 2 □ No Specify: HISPANIC þ 3 Widowed 4 Divorced Year or Dates: "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE and Mental Hygiene. is marked other than HOMEMAKER 6 YEARS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) as 1 and 2 should be fill of Health and Mental H item 27 is marked oth Be BEATRIZ RODRIGUEZ GREGORIO ESTRADA မှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2027 TINKER DRIVE, FT. WASHINGTON, MD 20744 NELLY G. MONTES-LUKAS (FRIEND) 20b. Place of Disposition (Name of JARDINES DEL BUEN RETIRO 20c. Location - City or Town, State Pages 1 20a. Method of Disposition JANUARY permit. Pages 1 Department of I Important: If ite any Injury or ot PUENTE PIEDRA XXBurial 2 Cremation 3 Removal from State 2010 4 ☐ Donation 5 ☐ Other (Specify) LIMA, PERU 21. Signal of Funeral Service Lice e 22. Name and Address of Facility
TERRENCE L. JOHNSON FUNERAL SERVICE, PA
4433 WHITE PLAINS LANE, WHITE PLAINS, MD TERRENCE L. JOHNSON#M00993 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on such line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** "Henos claroti 14 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of): Box 68760 physician Physician/Medical the attending f as 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 Other (specify) ∐Yes 2**X**∏Xlo P.O. the detached 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed 1 □ Yes 2/□No 1 ☐ Yes 2 ☐ No Division of Vital Physiclan: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 \(\text{Nursing Home} \) \(\frac{5\text{N}}{2}\text{Residence} \) \(6 \) \(\text{Other} \((Specify) \) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 💢 📆 📆 Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred ne Hospital or Attending P n 24 hours after death. ne Funeral Director: After t After 5 Pending investigation **M**aturai 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide TTCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 065365 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tingsfall Hol foil Unday a NA 207 (11

State Registrar

DHMH 17 Rev 1/2001

Date filed (Month, Day, Year)

JAN 1 1 2010

11701

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ohn Edward Fre		State of Maryland / Department of Health and Mental 1-For State Registrar Certificate of Death	Hygiene	Reg. No. 201	0 01364	
Physicia Medical Examii	ın/	1. Decedent's Name (First, Middle,Last) John E. Freeland	2. Date of D Month January	eath Day Year	3. Time of Death 2135 hrs	
		4a. Facility Name (if not institution, give street and number) 367 Fletchwood Road Apt. 3A Elkton		4c. County of I		
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Months Days Hours M		Birth(MM/DD/YYYY) : /1953	9. Birthplace (State or Foreign Country) IL	
w any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits	
Maryland r 28a-f sho	Director	MD Cecil Elkton 10e. Street and Number 10f. Zip Code 367 Fletchwood Rd. Apt. A3 21921		10g. Citizen of What		
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23s or 28s-f show or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Di	11 Marital Status 1 Never Married 2 Married 3 Widowed 4 X Divorced of Plass: 1		No- 14. Race - / White, 6	ice - American Indian, Black, hite, etc. 'hite	
5-0036 led within 72 hours afte Hygiene. other than "natural", the Medical Examine.	Completed b	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 3 Manager	retired)	16b. Kind of Busin Restau		
21215-0036 July be filed within 7 I Mental Hygiene, marked other than ic event, the Medica	Be	Harry F. Freeland, Sr. Marga	ret W	e, Maiden Sumame) Veismille		
e, MD 2. and 2 should Health and M item 27 is m;	۱۹	19a. Informant's Name/Relationship (Type, Print) Alicia Freeland (daughter) 19b. Mailing Address (Street and Number of Print) 71 West George A	ve Cor	tumber, City or Town, tland, IL	60112	
Baltimore, permit. Pages I an Department of Hee Important: If iten injury or other tr		4 Donation 5 Other Specify: Cemetery 21. Signature of Funeral Service Licens Address of Facility HOI		0Springf		
Physician	\dashv	M00784 PO BOX 2866, WILM. 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardial failure. List only one cause on each line.	INGTON I			
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic Cardiovascular Disease Due to (or as a consequence of):			Death	
b:	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): C. Due to (or as a consequence of):				
be executed sician and urial - transit	dical	d. UNPENDED AMENDED				
		IF FEMALE. 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnant at time of death 5 Other (Specify) 9 Unknown	gnancy	23d. Date of de Month	llivery Day Year	
, P.O. E res that the d signed by the be detached	≦	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			te to the cause of death? Probably 4 Unknown	
of Vital Records, P.O. in Physician: The law requires that the Net rhis certificate has been signed by meral director, page 2 should be detach	Completed	25. Was case referred to medical 26. Place of Death (Chec	1 Per	opsy pric	re autopsy findings available or to completion of cause of ath? Yes 2 No	
F Vital F Physician: r this certifi	To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other,4 Nur	sing Home 5	Residence 6		
ivision or Attendia after death Director: A	Certification:	27. Manner of Death 1 V Natural 5 Pending Investigation 3 Suicide 6 Could not be determined (Specify) 28a. Date of Injury (Month, Day,Year) 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No 28e. Place of Injury - At home, farm, street, factory, office building, etc.			or Rural Route Number, City	
To the Hospital within 24 hours To the Funeral completely filler	Medical Cer	4 Homicide determined (Specify) 29a Certifier (Check only one) 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred				
To the within To the comple	Med	and manner stated 29b Signature and title of certifier 29c. License number			(Month, Day, Year)	
20		30. Nam and address of person who completed cause of death (Item 23a)	D 24204	January 8, 20		
		Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, M 31 Date filed (Month, Day, Year) 32. Registrar's Signature	U Z 1 Z U 1		······································	
Regist	rar	JANII WIN Come B. Jane			·	

DHMH 17 Rev 1/2001 OCME 2006

OCME

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 01-05 Day 2010 Physician/ . Farrow, James A Medical 4a Facility Name (if not institution, give street and number) 4b. City Town, or Location of Death 4c. County of Death Examiner softer Hospice at the Juli Skour comico hake If Under 1 Year | If Under 24 Hrs. 98. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral 1 X M 2 □ F Months MD Country) 93 Director 24-1916 213-22-7039 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene.

Important: If item 27 is marked of other than "natural", or items 23a or 28a-f sho array injury or other traumafic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No MD Dorchester Hurlock 10f, Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral U.S.A 4422 Elwood Camp Road 21643 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces Black, White, etc. þ 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify Black Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Mechanic <u>Acme Markets</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 <u>Janie Chester</u> James A. Farrow, 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary E. Farrow/Wife Elwood Camp Rd, Hurlock, MD 21643 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Washington Cemetery1_11-201dHurlock, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 917 W. Isabella St Bennie Smith 917 W. Isabella St Funeral Home Salisbury. 23a. Par. 1. From the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoot in heart failure. List only one cause on each line.

Immediate Cause (Final Interval Betweer Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) To the Hospital or Attending Physician. The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Year Day Pregnant at time of death 2 🗌 No been signed by the sahould be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an e 2 s autopsy 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Hospital: Other: 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) HESPICE 27. Manger of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation To the Funeral Director: completed filled in by the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0058410 05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21802 31. Date filed (Month, istrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 07:30 10 Medical acility Name (if not institution, give 4b. City 4c. County of Death **Examiner** Town, or Location of Death LTIMORE If Under Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 M 2 F Months Hours Min Director (ARVIAND shov 10a. State 10b. County 10d. Inside Çity Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked outher than "natural", or items 23a or 28a-f sho any injury or or 10c. City, Town or Location Director 1 Yes 2 No ALTIMORE 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12, Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian. Armed Forces Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. <u>^</u> 1 Never Married 2 Married 2 No 1 ☐ Yes 2 ☑ No Specify: If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DQ NOT use retired) 15. Decedent's Education Maryland 21215 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) BINDER. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Numb or Rural Route Number, City or Town, State, Zip Code) MARY J. DIXON Page 1 and 2 SISTER ・スリノスマ Baltimore, 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cren 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) Cremation 3 - Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ODENTON, Signal a DAUGHERTY DUNG AND HOME Part 1. Enter the disease, his that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List & cause on each lin Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Diseass or linjur) that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 mor Dav Pregnant at time of death 1 Yes 2 No 4 ☐ Pregnant a 9 ☐ Unknown ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. cate has been signed in page 2 should be det 23e. Did tobacco use contribute to we cause of death? ğ Records, Completed 2 🗌 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, to the Hospital or Attending Physician: Division of Vital Be 25. Was case referre 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manney of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Yes Investigation Could not be Accident Angela Suicide
Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Cortifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the a 횬 29b. Signature and title of certifie 29c. License number 30 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

Hance

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 2010 JANUARY 1, 22:30 MARIAH FORD 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death PRINCE GEORGE HOSPITAL CHEVERLY PRINCE GEORGE 5. Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Min. Hours 1 □ M 2 🗓 F Days 218-20-0664 10-13-1924 MARYLAND Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits PRINCE GEORGE GLENARDEN 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7912 TYLER STREET 20706 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 ☐Yes 2 No If Yes, Give 1 Never Married 2 Married 1 □Yes 2 No Specify: BLACK 3 ₩ Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) DIETICIAN GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)

LINCOLN CEMETERY 1-9-2010

FLORENCE A. HAMILTON

20c. Location - City or Town, State

BRENTWOOD, MD

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

22. Name and Address of Facility JB JENKINS FUNERAL HOME

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

1-4-2010

7912 TYLER STREET GLENARDEN, MD 20706

Physician /Medical Examiner

Physician

Examiner

Funeral

Director

28a-f show

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.

Lip crant: If item 27 Is marked other than "natural", or items 23a or 28a-f show in hiury or other traumatic event, it is widen Evan in a rural bun this of one.

Baltimore, Maryland 21215-0036

72 hours after death with the Maryland

/Medical

10a. State

MD

ROBERT R. GANTT

20a. Method of Disposition

19a. Informant's Name/Relationship (Type. Print)

3 ☐ Removal from State

DESRAE BOONE/DAUGHTER

1 Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)

Director

Funeral

≥

Completed

Be

ပ

g physician and as the burial-transit attending pl signed by the a been si page 2 s certificate funeral After t

Examine Physician/Medical Completed by

Be

Certification: To

Medical

2K No

29b. Signature and title of certifier

SWAPNA_GADDIPATI,

JAN 0 7 2010

5 Pending investigation

6 Could not be determined

raddipat

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 ☐ Yes

27. Manner of Death 1 Natural

2 Accident

4 ☐ Homicide

3 Suicide

29a. Certifier (Check only one)

n 24 hours after death.

ne Funeral Director: Af
bletely filled in by the fur

law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 the Hospital or Attending Physician: The

State Registrar

11-11	7474 LANDOVER RD LA	NDOVER, MD 2	20785
23a. Part 1. Enter the disease, or or shock, or heart failure. List or	omplications that caused the death. Do not enter the mode of dying, such as cardiac nly one cause on each line.	or respiratory arrest,	Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition	METASTIC BREAST CANCER		Oriset and Death
resulting in death)	Due to (or as a consequence of):		
Sequentially list conditions, if any leading to immediate cause. Enter Underlying	b. Due to (or as a consequence of):		
cause. Enter Underlying Cause (Disease or injury that initiated events	c.		
resulting in death) Last	Due to (or as a consequence of):		
	d		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1	2:	3d. Date of delivery Month Day Year
Part II. Other significant condition	s contributing to death but not resulting in the underlying cause given in Part I.		e contribute to the cause of death?
		1∐Yes 2L] No 3 ☐ Probably 4 ☑ Unknown
		24a. Was an autopsy performed? 1 □ Yes 24 □ No	24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 □No
25. Was case referred to medical examiner?	26. Place of Deat	h (Check only one)	

28c. Injury at Work?

TC Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

1 ☐ Yes 2 ☐ No

DOO 69341.

DRIVE CHEVERLY, MD 20785

20b. Place of Disposition (Name of cemetery, crematory or other place)

1√ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

Injury

28a. Date of Injury (Month, Day, Year)

M.D

3001 HOSPITAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Ellen Griffin 5:15 ам 2010 January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Kensington Park Retirement Center Kensington Montgomery 8. Date of Birth (Month, Day, Year) Feb. 12, 1920 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Days Hours 1 M 2 X F Virginia 216-18-0655 89 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director be notified or 28a-f 1X Yes 2 No Maryland Montgomery Kensington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral and 2 should be filed within 72 hours after death with Health and Mental Hygiene. 3616 Littledale Road, Apt. 209 20895 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 9 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Specify: White 3 Widowed 4X Divorced Completed Year or Dates is marked other than "naturaumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Bookkeeper Family Owned Business Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Henry M. Brunk Nora Ellen Kraus 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2406 Hayden Drive, Silver Spring, MD 20902 Ruth Prindle/Daughter 27 Department of Health Important: If item 27 any injury or other to once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 🗷 Burlal 2 🗆 Cremation 3 🗆 Removal from State Jan. 2010 Fort Lincoln Cemetery Brentwood, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Eachity Francis J. Collins Funeral Home 500 University Blvd. W., Silver Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that c Nsed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Atherosclerotic Heart Disease disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Pulmonary Hypertension Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a nonsequence of attending physician and for use as the burial-transit Congestive Heart Failure that initiated events Due to (or as a consequence of): resulting in death) Last Be Completed by Physician/Medical Arthritis law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death 2 XNo been signed by the should be detached 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? History of Hypertension, History of Pulmonary Embolism Records, 1 ☐ Yes 2 ☐ No 3 🔀 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 performed? or Attending Physician: The 1 ☐ Yes 2 ☐ No Yes 2 K No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 1 🗌 Yes 2 😾 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify) uneral Director. After the dilled in by the for-28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Sulciue 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Hospital 24 hours Medical 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the Hosp within 24 hou To the Funer completed fil Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse etioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D53691 Jan. 5, 2010 30. Name and address of person who completed daute of death (Item 23a) (Type, Print) 3200 Tower Oaks Blvd. Ajay Reddy, MD #100, Rockville, MD 20852

State

Registrar

31. Date filed (Month, Day, Year)

JAN O

6

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day CORA **GIDDENS** 2010 ANUARY Medical 4:40A 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death ARCOLA HEALTH & REHABILITATION SILVER SPRING MONTGOMERY 5. Social Security Number Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) If Under Funeral 8. Date of Birth 9. Birthplace (State or Foreign 1 ☐ M 2¾ F Days Hours 09-30-1918 Yrs. NORTH CAROLINA Director 075-22-7537 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD PRINCE GEORGE COLLEGE PARK 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 9314 CHERRY HILL RD #703 20740 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. δ 1 Never Married 2 Married 1 ☐ Yes 2 [If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 hours after 1 ☐ Yes 2 X No Specify: er than "natural", the Medical Exa Specify: BLACK 3X Widowed 4 □ Divorced Completed Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) e 1 and 2 should be filed with of Health and Mental Hygien If item 27 is marked other th or other traumatic event, the 4th HOMEMAKER PRIVATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ FRANK WHITEHEAD NONIE JONES 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 st Department of Health ar. Important: If item 27 is 1 any injury or are 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code ELAINE GIDDENS/DAUGHTER 9314 CHERRY HILL RD #703 COLLEGE PARK, MD 20740 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1-7-2010 GATE OF HEAVEN SILVER SPRING, MD 22. Name and Address of Facility JB JENKINS FUNERAL HOME Funeral Service Licensee 21 Sign 150 7474 LANDOVER RD LANDOVER, MD 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final ACUTE RENAL FAILURE Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner DIABETES MELLITUS Sequentially liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Examin Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician a the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year been signed by the should be detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖄 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page performed? Yes 2 No this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Hospital Other: 1 Tes 2 X No မ Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending after death Director: A d in by the fi Accident М 1 🗌 Yes 2 🗌 No Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined filled in 24 hours a Funeral L Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 ho To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. e and title of certifier 29d. Date signed (Month, Day, Year) D34472 1-6-2010

State Registrar

DHMH 17 Rev 7/2009

ype, F AVE

SUITE 206 KENSINGTON, MD 20895

ddress of person who completed cause of death (Item (3a) (ADTGCS MD, 10400 CONNECTION)

32. Registrar's Signature

addre

31. Date filed (Month, Day, Year)

JAN 0-7 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND ITEM#21perFD, G899, 172272010, WS/#8, perFH, G900, 272/10, WS/State of Maryland / Department of Health and Mental Hygiene / [] [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year 1-13-2010 **Physician** 8:20 A^{M} Elaine S. Grumbine /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner College View Center Frederick Frederick If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea, 2-12-1921 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☐ M 2 ☐ XF 526-26-9968 Α7. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examination out to maithed at 1 □Yes 2 No Director Charlestown WV Kanawha 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 234 Harrow Place 25414 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 MNo If Yes, Give Ye ar or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any injury or other traumatic event, Its Medical Exerci-1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. þ Specify: 3 Nidowed 4 Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) School Teacher Fducation 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mattie Cowan George E. Stermer 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 234 Harrow Place Charlestown WV 25414 Joseph Grumbine Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Olivet Cemetery 1-15-2010 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Keeney & Basford P.A. F.H. 21. Signature of Funeral Service Licensee M01176 106 East Church Street Frederick, MD 21701 John A. Skaro perDVR 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ementia Immediate Cause (Final disease or condition resulting in death) **Physician** HONTHU. /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be execute that initiated events resulting in death) Last burial-tra Due to (or as a consequence of): physician the burial-Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No Month Day Vear Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Récords, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 ☐ Yes 2 ☐ No 1 □Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide fo the within 24 hour.
•he Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature an D0062223 ress of person who completed cause of death (Item 23a) (Type, Print) ND 1967JDLIVE PREDERICE, MD 2/702 BOCHRUM reaveen 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** 2010 January Mildred Onieda Gordon /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner St. Mary s Hospital 5. Social Security Number 6. Sex Leonardtown If Under 1 Year | If Under 24 Hrs. St. Mary's Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral Months Days Hours 1 ☐ M 2 🖫 F Director 84 08/07/1925 North Carolina 579-36-8808 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County "natural", or items 23a or 28a-f show Director Maryland | St. Mary's Dameron 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20628 17311 Three Notch Road United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: Completed by 3 Nidowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) other than Hygiene. 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othe any Injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) Be ပ John Henry Powell, Sr. Jennie Lambertson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Felicia D. Greene/Aunt P.O. Box 242, Dameron, MD 20628 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Peter Claver Cem. 01/15/2010 St. Inigoes, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signature of Funeral Service Licensee Kyle S. Simons 22955 Hollywood Road, Leonardtown, MD M01206 23a, Part 1. Enter the disease, or complications that cruised the death. Do not enter the mode of dung, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on path line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical for as a consequence of): Examiner Se quentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physician/Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

<u>6:3</u>7

10d. Inside City Limits

Approximate Interval Between Onset and Death

Year

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

23d. Date of delivery

Month

Black

1 ☐ Yes 2 ☑ No

p.m.M

as Box (been signed by the atte should be detached for o. ۵. sion of Vital Records, has certificate this

Hospital or Attending 24 hours after death. Director; d in by the To the Hospital o within 24 hours aft to the Funeral Di completely filled in

Completed by

Be

Certification: To

Medical

4 Pregnant at time of death 9 Unknown 5 Other (specify) 1 ☐ Yes 2 🗹 No 9 I IInknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ement 74 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death

29a. Certifier

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

025230

3 Ectopic pregnancy

29b. Signature and title of certifier

29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

25500 Point Lookout Road, Leonardtown, MD David Allen, M.D. 31. Date filed (Month

WIL

State Registrar

BA

10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

			1 - For State Registrar		<u>.</u>	f Maryla			t of H	lealth a		lental Hyg	eg. No.	10	01372
н	Physici	an	Decedent's Name (First, in the control of the	Middle, Last								Date of Deat Month	th Day	Year	3. Time of Death
	/Medi		Thomas	C.		Godwin						Jan.	_	010	6:35P ^M
	Examir	ner	4a. Facility Name (If not inst	-	street and nun	nber)				Location o	f Death			nty of Death	1
			24 Doe Driv 5. Social Security Number	e 6. Se		7 Age //n vr	s. last birthday		lkto 1 Year		24 Hrs.	8 Date of Birth		Cecil	anlana (State or Foreign
	Funeral Director		222–16–9668 Usual Residence of Decede	15	M 2□F	7. Age (III yr.	80 Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day, Feb. 15,	1929	Wilm	nplace (State or Foreign untry) ington, DE
	ow ow		10a. State 10b. Co			10c. 0	City, Town or L	ocation							10d. Inside City Limits
	within 72 hours atter death with the Maryland ene. then 'naturel', or Items 23e or 28e-f show the Marical Exchiter must be notified at	Director	MD C	ecil			E1kto		Cado				On Citizon	of What Co	1 ☐ Yes 2 🛣 No
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	ter d	Ę	1 Never Married 2	Married	Armed Fo	rces?		If Yes, spec	ify Cuba	n, Mexican	, Puerto	Rican, etc.)		Black, White	
Maryland 21215-0036	72 hours after dea "naturel", or Items	d by I	3 ☐ Widowed 4 ☐ Div	orced	If Yes, Giv Year or Da	re		1 🗆 Yes		Specify:					white
7	permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natur any injury or other treumetic event, the Madical ang fig.e.	Completed	15. Dec (Specify only i	edent's Edu highest grad	e completed)		(Give	dent's Usua kind of wo	rk done d	during most	of worki	ng		f Business/I	
12	within hen hen	E D	Elementary/Secondary (0	-12)	College (1	-4or 5+)		DO NOT us		"			U.S	. Pos	
2	filed v Hygie other t	ပိ	17. Father's Name (First, Mi	ddle [ast]	1	•	Su	pervi	sor_	18 Mothe	r's Name	(First, Middle, I	Maiden Sum		rvice
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	1 and Health em 27 ther tr		Elizabeth (20a. Method of Disposition	Godwir	_(wife) 20h	Place of Disp	Doe		ve E.		n, MD	21921	on - City or 1	Town State
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Baltimore,	permit. Pag Department Importent: I any injury c		21. Signature of Funeral Se	rvice Licens	BMO	9734	۲ .	2. Name an			rice	Crery Fu			
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	Physician /Medical	S 1	23a. Part1. Enter the diseashock, or heart failure. Immediate Cause (Final disease or condition resulting in death)	List only o	ne cause on e	ach line.	heroscl			-		er respiratory arr	981,		Approximate Interval Between Onset and Death
8760,	ate be executed by hysician and inhe burial-transit and	lical Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	{	Due to (or as a conse	Auence of:								
P.O. Box 68	The law requires that the death certificat sie has been signed by the attending phy page 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnal in the past 12 months? 1 Yes 2 No 9 Unknown	וו זר	_	irth 2 ☐ Fe ant at time of	tal death 3[⊒Ectopic pr ⊒ Other <i>(sp</i>						Date of deline	very Day Year
	quires tha n signed I uld be det	5	Part II. Other significant co	nditions co	ntributing to de	eath but not re	esulting in the u	inderlying c	ause give	en in Part I.		1	oacco use c es 2 □ No		the cause of death? obably 4 🗹 nknown
Vital Records,	The law requir sate has been si page 2 should	Completed				-						24a. Was a autops perform	n. 24 ned?	death?	topsy findings available completion of cause of
ita	iiclen: Th certificate rector, pag	Be (25. Was case referred to me examiner?	edical						26. Place	of Death	(Check only on	θ)		
>	d is	으	1 ☐ Yes 2 ☑ No	H	Hospital: 1 □ II	npatient 2	☐ ER/Outpatie	nt 3 DC	Othe	er: 4 □ Nu	rsing Hor	me 5 Reside	ence 6 🗆	Other (Spec	cify)
ion of	nding Ph tth. :: After thi e funeral			ending vestigation	28a. Date o (Mont	of Injury h, Day Year)	28b. Time o Injury	of 2	8c. Injury Work	/at <br Yes 2□!		28d. Describe ho	ow injury oc	curred	
Division	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: Attercompletely filled in by the fune.	Certification;		ould not be etermined	28e. Place building	of Injury - At ng, etc. <i>(Sp</i> e	home, farm, st cify)	reet, factory	, office			28f. Location (St City or Town		imber or Ru	ral Route Number,
	To the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in by	Medical (29a. Certifier 1 Cer (Check only one) 2 Mer	tifying Phy dical Exami	ner : On the ba	best of my ka asis of examin ner stated.	nowledge, deat nation and/or in	h occurred ivestigation	at the tim , in my or	ne, date and pinion, deat	d place, a	and due to the ca ed at the time, d	ause(s) and ate and plac	manner as ce, and due	stated. to the cause(s)
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	4		30. Name and address of pe	EV /	mpleted caus		em 23a) (Type	Print)	St,	E	26te	n MD.	2192	1.	
	Sta Registr		31. Date filed (Month, Day, JAN 0 7	^{Year)} 2010		egistrar's Sig	nature	U							

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Louise Roberts Harrell January 5, 2010 2:30a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore Note: 1 Vear | If Under 24 Hrs. 8800 Walther Blvd, Apt. 1207 Baltimore Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 😡 F Months Days Hours Min 215-14-1164 Director 12/26/1921 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" -- any injury or other traumatic exercises. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits **Funeral Director** MD Baltimore Baltimore 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8800 Walther Blvd., Apt. 1207 21234 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 1952 Year or Dates: 1056 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc 1 ☐ Never Married 2 ☐ Married 1952-1 ☐ Yes 2 No Specify ģ white 3 Widowed 4 Divorced 1956 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Teacher of the handicapped 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be W. Maurice Roberts Gertrude Lakel ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty R. Hershfeld, sister 4600 Lower Beckleysville Rd., Hampstead, Md. 21074 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State Mount Olivet Cemetery 1/7/2010 Frederick, Md. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Eline Funeral Home M00741 Semmer 934 South Main St., Hampstead, Md. 21074 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physiclan ASC disease or condition resulting in death) ' /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) and resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be seen to after death. Ed hours after death. Funeral Director: After this certificate has been signed by the attending physician releily filled in by the funeral director, page 2 should be detached for use as the buring their filled in by the funeral director, page 2 should be detached for use as the buring. Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) ☐Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 □Yes 2 No 1 ☐ Yes 2 🗆 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Injury at Work? 1 Natural 5 Pending investigation 1 Tyes 2 🗆 No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a 1/2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

of Vital Records. Division

P.0.

WJL

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day

Monics

Ither

strar's Signature

29c. License number

D 58646

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8800

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar 01375 Reg. No. 4 U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Louise Mae Hinton 4.30 AP 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Carroll Hospital Center Westminster If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex Funeral 1 □ M 2 1 F Months Days 213-24-3645 95 Director Feb 3, Maryland 1914 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examinant rust be notified at 1 ☐ Yes 2 No Directo Taneytown Maryland Carroll 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 4027 Baptist Road 21787 23aUSA Funeral or items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify þ white Specify: 3 ₩ Widowed 4 □ Divorced "natural" Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) of Health and Mental Hygiene. fitem 27 is marked other than other traumatic event, Ins. M. College (1-4or 5+) Own Home 12 Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jesse Connors Thomas Crown ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4027 Baptist Road, Taneytown, MD 21787 Melody Smith, daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of Important: If it any injury or conce. 1 🖼 Burial 2 □ Cremation 3 □ Removal from State 01/07/2010 Frederick, MD 4 Donation 5 Other (Specify) Resthaven Memorial 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Myers-Durboraw Funeral Home 136 E Baltimore St, Taneytown, MD 21787 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disese lidno disease or condition resulting in death) NYONI /Medical Due to (or as a consequence of): Examiner 5 trem ac Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran hen mous Due to (or as a consequence of): P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) s been signed by the should be detached 1 ☐Yes 2 ZNo 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? After this certificate has funeral director, page 2 s 24a. Was an 2 No 1 ☐Yes 2 ☐ No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: Air completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) WJL 75433 201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ASHRAF, MD

DHMH 17 Rev 1/2001

State

Registrar

MAHBOOB

31. Date filed (Month, Day, Year)

JAN 05

park

32. Registrar's Signature

MEMORIAL NE.

MD 21157

WESTNINSTER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last)
Rosalind Humphries 2. Date of Death 3. Time of Death Physician/ 101703/2010 11:35 p M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Washington Adventist Hospital Takoma Park MD Montgomery County 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Days Hours 1 □ M 2 🙀 7/13/1943 66 Yrs. Washington DC 577-56-7422 Director Usual Residence of Decedent 10c. City, Town or Location Washington 10a. State 10b. County 10d. Inside City Limits with the Maryland items 23a or 28a-f sho her must be notified at Director DC 1 TYes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20019 4946 Jay Street NE United States permit. Page 1 and 2 should be filed within 72 hours after death N Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Black 3 Midowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Paralegal U.S. Attorney Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Gertrude Tinker John Humphries 3b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4946 Jay St. N.E. Washington D.C. 20019 19a. Informant's Name/Relationship (Type, Print) Sean Humphries Son 20a. Method of Disposition 20b. Place of Disposition (Name or 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) cemetery, crematory or other place) 01/08/2010 Landover MD armony Park Signatu of Funeral Service Lice 22. Name and Address of Facility John T. Rhines Funeral Home LLC 12th Street N.E. Washington D.C Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Physician/ Chronic Under to (or as a consequence of) disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Pregnant at time of death ed by the a detached f Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed k 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown cate has been sig page 2 should b 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy certificate | Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 🗷 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending Natural Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 29b. Signature and title certific 29d. Date signed (Month, Day, Year) Lex CN, 124 Bocie State Registrar

DHMH 17 Rev 7/2009

			For State Registrar	State of Ma	aryland / Depa <i>Cei</i>	artment of F rt <i>ificate of</i>			iene eg. No.2010	01377
	THE PERSON		Decedent's Name (First, Middle, Last	")				2. Date of Deat	h	3. Time of Death
	Physici		Catherine	R.		Harrison	n	January	Day Year 7 5 2010	8:25 PM M
3	/Medic		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	or Location of Death		4c. County of Death	10.25 111
4			Wicomico Nursing	g Home		Salis			Wicomico	
	Funeral		Social Security Number 6. Se		e (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	rear) Cou	place (State or Foreign ntry)
A	Director		216-09-0587		96 Yrs.			9-27-19	13 Man	yland
	land ow It		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
	Mary -f sh	to	MD Wicomi	60	Salisbu	rv				1 ☐ Yes 2X No
	r 28a	irec	10e. Street and Number		Dalibba	10f. Zip Code		1	0g. Citizen of What Cou	ntry?
	th with	a D	27206 Hitching Pos	t Lane			21801		USA	
	ems ems	Funeral Director	11. Marital Status	12. Was Decedent ! Armed Forces?	Ever in U.S. 13.	Was Decedent of H	lispanic Origin? (S an, Mexican, Puert	pecify Yes or No-	14. Race - Ameri Black, White,	
98	within 72 hours after death with the Maryland tene. than "natural", or ftems 23a or 28a-f show he Mcdical Examiner must be notified at	J. F.	1 Never Married 2 Married	1 ☐ Yes 2X11 If Yes, Give	10	1 ☐ Yes 2 % ☐ No	Specify:	,,		Thite
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15	n 72 "nad	Completed	15. Decedent's Edu (Specify only highest grad	le completed)	(Give	kind of work done DO NOT use retire	during most of wor d)	king	16b. Kind of Business/Ir	dustry
212	withi iene. than the M	E I	Elementary/Secondary (0-12)	College (1-4or 5	+)	Homemal			Own Home	•
D	e filed other	BeC	17. Father's Name (First, Middle, Last)					ne (First, Middle, M	Maiden Surname)	
lar	uld be denta rked rtc ev	To B	William		Winkleman		Louise		Mi	.1ke
Maryland	and land lis ma		19a. Informant's Name/Relationship (T)	vpe. Print)	19b. Mailir	ng Address (Street	and Number or Ru	ıral Route Number	, City or Town, State, Zi	code)
≥	and sealth n 27		William R. Harrisc	n – Son			g Post La		sbury, Mary	
Baltimore,	ges 1 t of H if Itel	-	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ I	Removal from State	20b. Place of Dispo cemetery, crei	sition (Name of matory or other pla	сө)	Date	20c. Location - City or T	own, State
Įį,	tmen tant:		4 Donation 5 Other (Specify,)	Springhil				Hebron, Mar	yland
Bal	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the M-dical Examiner must be notified at once.		21. Signature of Funeral Service Licens			2. Name and Addre	. 1		neral Home	
			23a Part1 Enter the disease or comp	lic fights that caused					ury, Maryl <u>a</u>	
H	Dhf-f		23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final	ne 🗠 se on each lir	ie.		D = -	- Copilatory and	501,	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Due to (or as	a consequence of):	14	VERY	[W]/	4.	
	Examiner	Ш		L						
		ner	Sequentially list conditions,	Due to (or as	a consequence of					
	icate be executed physician and s the burial-transit	dical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с						
90,	e execian a	Ě	resulting in dealth) cast	Due to (or as	a consequence of):					
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Box	death certiff e attending id for use as	cian	in the past 12 months?		2 Fetal death 3	Ectopic pregnanc Other (specify)	у		23d. Date of deliv	Day Year
P.O.	the d y the iched	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unknown						
σ,	The law requires that the death certific ite has been signed by the attending page 2 should be detached for use as	by Pt	Part II. Other significant conditions co	ntributing to death b	ut not resulting in the u	nderlying cause giv	en in Part I.	23e. Did tob	acco use contribute to	he cause of death?
Records,	quire en sig uld ba	q pe						1 □ Ye	es 2 No 3 Pro	bably 4 Unknown
O O	aw re	Completed						24a. Was ar	n 24b. Were aut	opsy findings available
Ä	The law cate has page 2.	mo						autops perform 1□ Yes 2	ned?// death?	ompletion of cause of 2 ☐ No
Vital	ician: Th certificate ector, pag	Be C	25. Was case referred to medical examiner?				26. Place of Dea	th (Check only on		
or V	Physician: this certific	To E	1 ☐ Yes 2 ☐ No	Hospital: 1 🗀 Inpatie	nt 2 ER/Outpatier	t 3□ DOA Oth	ner: 4 Nursing H	ome 5 Reside	ence 6 □Other (Speci	fy)
		ü	27. Mann of Death 1 ☐ atural 5 ☐ Pending	28a. Date of Inju (Month, Day		Wor	ry at rk?	28d. Describe ho	w injury occurred	
sio	Attending r death. ector; After by the fune	cati	2 Accident Investigation 3 Suicide 6 Could not be	00 8			Yes 2 □ No			
Division	Il or Attendi after death. I Director: A d in by the fu	Certification:	4 Homicide determined	building, etc	ury - At home, farm, str c. (Specify)	eet, factory, office		28f. Location (St. City or Town	reet and Number or Rur n, State)	al Route Number,
_	pital		29a. Certifier 1 Certifying Phy	sician: To the hest	of my knowledge, deat	h occurred at the ti	me, date and place	and due to the co	ause(s) and manner as	etated
	e Hos 24 h e Fur letely	Medical	(Check only 2 Medical Exam one)	iner: On the basis of and manner sta	f examination and/or in	vestigation, in my	opinion, death occu	irred at the time, d	ate and place, and due	to the cause(s)
	To the Hospital or Attenc within 24 hours after death To the Funeral Director; completely filled in by the	Me	29b. Signature and title of certifier			29c. Licens	se number	25	9d. Date signed (Month,	Day, Year)
	ſ		V/MMnan	lmsii		D 6	051.5		116/10	
	Yans		30. Name and address of person who c	ompleted cause of d	eath (Item 23a) (Type,	Print)	()			
	9-1		Mahesha Thimmaray		-		Dr Sali	sbury MD	21804	
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registra	ar's Signature	back				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 201^{Year} **Physician** 5:00 P January 12, Frank Edward Harris /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Caroline 23908 Denton Willow Pond If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, June 30 Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) Social Security Number **Funeral** 1 🔀 M 2 🗆 F Months Days Hours Min. 1944 Maryland Director 213-44-0344 65 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County r than "natural", or Items 23a or 28a-f show 1 ☐ Yes 2 € No Directo Denton Caroline Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States of America 23908 Willow Pond Road 21629 by Funeral 12. Was Decedent Ever in U.S.
Armed Forces?

1 ™ Ses 2 □ No 1965If Yes, Give
Year or Dates: 1967 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify Specify: Caucasian 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: If Item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) Farming 12 Farmer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Boyles Onito Edith Dorsey Harrington Harris 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health a Important: If Item 27 Is any injury or other trau once. 23908 Willow Pond Road, Denton, Maryland 21629 Wife Doris S. Harris 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date K□ Burial 2 □ Cremation 3 □ Removal from State Cemetery 1/16/2010 Denton, Mary1 22. Name and Address of Facility Moore Funeral Rome, P.A. Denton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Denton Cemetery Ture of Funeral Service Licenses en copel Moure 12 South Second Street, Denton, Maryland 21629 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) **Physician** LUNG CANCER 2 YEARS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initialed events resulting in death) Last Examine Due to (or as a consequence of) Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): physician s the burial Box 68760, Physician/Medical attending p for use as t 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 ☐ Pregnant at time of death 5 Other (specify) P.0. signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 Yes 2 No 3 Probably 4 Unknown Completed s certificate has birector, page 2 sl 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy perform 1 ☐ Yes director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Other: 4 Nursing Home 5 KResidence 6 Other (Specify) 1 Tes Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending Natural 5 ☐ Pending investigation within 24 hours after death.

To the Funeral Director:

completely filled in by the fi 1 ☐ Yes 2 ☐ No ☐ Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D39887

State Registrar David H. Smith 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

ORIGINAL

Easton, Maryland

21601

8221 Teal Drive

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D

18 10x

		Flease	State of Marylan					•	ı
	,	1 - For State Registrar	o tato o maryian		rtificate of		, ,	g. No.2	01270
	.33	1. Decedent's Name (First, Middle, Las	t)				2. Date of Death Month	2016	3. Time of Death
Physici /Medic		Melvin		Iill			January	8, 201	1.4
Examir	ner	4a. Facility Name (If not institution, give			_	r Location of Death		4c. County of De	
Funeral		Envoy of Dento 5. Social Security Number 6. Se		last birthday)	Den 1 If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	Caroli	n e irthplace (State or Foreign
Director		214-28-8187	¥M 2□F 84	Yrs.	Months Days	Hours Min.	(Month, Day, July 25.	Year)	rvland
and w		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits
Maryl -f sho iled al	tor	Maryland Talbo	F	Easton					1, Yes 2 No
with the Maryland a or 28a-f show be notified at	Director	10e. Street and Number		Labton	10f. Zip Code		10	g. Citizen of What C	Country?
± 23 ±	ral	201 Federal Stree			21601				tes of Americ
ter dea items ner mu	Funeral	Marital Status Never Married 2 Married	12. Was Decedent Ever in U.S Armed Forces?	S. 13.	Was Decedent of H f Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh	
urs af al", or Ехаті	þ	3 Widowed 4 Divorced	1.□Yes 2 □ No If Y es, Give Year or Dates:		1 ☐ Yes 21 No	Specify:		Specify: Ca	aucasian
flied within 72 hours after de Hygiene. vther than "natural", or item ent, the Medical Examiner n	Completed	15. Decedent's Ed (Specify only highest grad	ucation de completed)	16a. Deced	dent's Usual Occup	eation during most of work d)	ina 1	6b. Kind of Busines	s/Industry
within ene. than '	Idmo	Elementary/Secondary (0-12)	College (1-4or 5+)			,	μč	retaking	/ Maintenance
filed 'Hygid Dather ther'	Be Co	17. Father's Name (First, Middle, Last)		Caret	aker and	Maintenan 18. Mother's Name	nce Man e (First, Middle, M.		Tariitelialice
uld be Vienta Irked Itic ev	To B	Herman H	. Hill			Sarah 1	Elizabeth	Hurlock	c
2 sho l and l is me	i	19a. Informant's Name/Relationship (7						City or Town, State,	Zip Code)
1 and Health em 27 ther t		7eri Hill 20a. Method of Disposition	Granddaughter 20b Pl		Market .	Street, D		aryland Dc. Location - City o	21629
permit. Pages 1 and 2 should be flied within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once.		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spacify	Removal from State	emetery, crer –	natory or other plac	ce)		,	
mit. F partme portan / injur		21. Signature of Funeral Service Loceb		Capito 22	L Cremato . Name and Addre	ory 1/12	/2010 re Funera	Dover, De 1 Home, I	laware
permi Depar Impor any ir		Kauchofut		1	2 South S	Second St	reet, Den	ton, Mary	land 21629
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Examiner			Die to (or as a consequ	ience of):					·
	ner	Sequentially list conditions, if my, backing to immediate cause. Enter Underlying Cause (Disease or injury	b. The to for as a consequ	ente of):					1
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ifficate g phys as the			d					T	
th cert ending	M/us	23b. was decedent pregnant	23c. If yes, outcome pf pregnar 1 □ Live birth 2 □ Fetal		Ectopic pregnancy	,		23d. Date of de	elivery
re dear the att	Physician/Medi	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant at time of de 9□Unknown		Other (specify)	<u> </u>		Month	Day Year
w requires that the death certificate been signed by the attending phy should be detached for use as the		Part II. Other significant conditions co	Intributing to death but not resu	Iting in the ur	nderiving cause give	en in Part I.	23e. Did toba	cco use contribute	to the cause of death?
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The late has page	Som						autopsy performe 1□ Yes 2	prior to death? ■No 1 □ Ye	
ician: certific ector,	Be	25. Was case referred to medical examiner?	Hospital:		T 0415		(Check only one)		
Phys r this ral dir	<u>۲</u>	1 ☐ Yes 2 ☐ No 27. Manner of Death	I □ Inpatient 2 □ E	ER/Outpatien 28b. Time of		4 Nursing Ho	me 5 Residen 28d. Describe how	ce 6 Other (Sp.	ecify)
nding tth. r: Afte e fune	ation	1 Natural 5 ☐ Pending 2 ☐ Accident Investigation	(Month, Day Year)	Injury	28c. Injun Work M 1 🗆	k?¨ Yes 2 □ No	200. 2000/100 /104	injury occurred	
or Atte ter dea irecto ir by th	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At hor building, etc. (Specify,	me, farm, stre	eet, factory, office		28f. Location (Stre City or Town,	et and Number or F State)	Rural Route Number,
pital o		One Condition 1 Condition Physics	alalam Ta Markata farahar						
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the	Medical	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	sician: To the best of my know iner: On the basis of examinati and manner stated.	viedge, deatr ion and/or inv	estigation, in my o	ne, date and place, pinion, death occuri	and due to the cau red at the time, dat	ise(s) and manner a e and place, and du	is stated. le to the cause(s)
To the vithin To the complete	Me	29b. Signature and title of certifler	1011	44	29c. License	e number	290	I. Date signed (Mor	
		> Millen	WAZ ATTEND	, UG M	DDOC	5309	4 1	-11-2	010
0.0		30 Name and address of posson who con the second se	mpleted cause of death (Item	23a) (Type, I	Print)	NAIL A	· L	10 4-0	OLIVI
Sta	te.	31. Date filed (Month, Day, Year)	32 Registrar's Signat	We /	LOPHIN(DITUEN	FULU ES	VCHUSIS	126,000
Registra	ar	JAN 1 2 201	10 Comma p	1. ADA	ale .				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** JANUARY 12 Year 2010 HENRY C. HAYWOOD, 5:20p M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Union Hospital Cecil Elkton If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Oct 22. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1944 Pennsylvania 1 X M 2 □ F 65 **Director** 218-40-4859 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 Is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the "Motical Examinar must be notified at Director 1 Yes 2 No MD Cecil Chesapeake City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 419 Hemphill St. Funeral 21915 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No 1964 If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ∐Yes 2 V No ģ Specify. White Specify: 3 ☐ Widowed 4 ☑ Divorced Year or Dates: -1967Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Corps of Engineers 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Henry C. Haywood, Sr. Nora M. O'Grady ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pamela Wadkins (daughter) 538 Marley Rd. Elkton, MD. 21921 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages
Department of
Important: If it
any Injury or o 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Old Bohemia Cem. 1/16/2010 Warwick, MD. 21. Signature of Funeral Service Licens 22. Name and Address of Facility
Galena Funeral Home of Stephen L Schaech 118 West Cross St. Galena, MD. M00510 21635 23a. Part. Enter live i isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or high refailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cay e (Final disease or condition resulting in death) hysician Cardiac /Medical Due to (or as a consequence of) Examiner A cute myo condical Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last S Exam attending physician and for use as the burial-tranunclear Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) ned by the a detached for □Yes 2□No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Shock 1 ☐ Yes 2 ☐ No 3 ☐ Probably 🏂 Unknown Cardio Cenic Completed ncordizi pon rele 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date, signed (Month, Day, Year)

State Registrar Street

145,400

06

32 Registrar's Signatu

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

JAN 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #5 State FH Maryland /25 /2010 Health and Mental Hygiene

		-	For State Registrar		State of Ma	i yiai iu	•		e of D			Reg. No.	201	0		381
	Physicia		1. Decedent's Name Mary	(First, Middle, Las	t)	Н	o11y				2. Date of Dea January		, žô.	ío	3. Time of E	Death PM
~	/Medic Examin		4a. Facility Name (If	not institution, give	street and number)			4b. City,	Town, or Lo	ocation of Death		4c. County of Death				
فممسيد		•	1418 Taney Avenue Frederick									Frederick				
I	Funeral Director		5 Social Security No. 283–36–31	95 '	ex y 7. Age □ M 2□ F 6		st birthday) Yrs.	If Under Months		f Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day 2-9-1	3 <i>Year)</i>	9. 8	Birthpla Countr	ce (State or y) Ohio	Foreign O
	iryland show	<u>.</u>	Usual Residence of 10a. State	10b. County		10c. City,	Town or Lo	cation						100	I. Inside City	
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	with th	늅	10e. Street and Num		D 100			10f. Zip	702			US.		Countr	y r	
	ns 23	Funeral Director	1418 1an	ney Avenu	12. Was Decedent E	ver in U.S.	13. \			panic Origin? (Sp	ecify Yes or No-		. Race - Ar	nerica	n Indian,	
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ite Budical Event, and to be notified at once.	þ		ed 2 Married	Armed Forces? 1 ∐Yes 2 N If Yes, Give Year or Dates:			fYes, sped I⊡Yes		panic Origin? (Sp Mexican, Puerto Specify:	Ricán, etc.)		Black, Wh	nite, etc Vhi		
21215-0036	nin 72 hou e. In "natura Modical I	Be Completed		15. Decedent's Ed	ucation de completed) College (1-4or 5-		16a. Deced (Give life. L	kind of wo OO NOT us	rk done dur se retired)	on ring most of work			of Busines		•	
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	is 1 and 2 of Health a Item 27 is		20a. Method of Disp	osition		20b. Pla	ace of Dispo				Date		ation - City		n, State	
Baltimore,	it. Pages rtment of I rtant: If Its njury or o		4 ☐ Donation	5 ☐ Other (Specify	-	1	of H	leaver	Cem	1-21	L-2010					
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68760,	hysician be executed as the burial-transit as the burial-transit	al Examiner	shock, or heal immediate Cause (disease or condition resulting in death) Sequentially list conit any, leading to him cause. Enter United Cause (Disease or that initiated events resulting in death) L	nt failure. List only of Final n haditions, mediate highly injury	b. Due to (or as a Due to (or a) Due to (o	e. Conseque	つら、人 ence of):			2-1mm			u		Approximate nterval Betwo	veen Death
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UC.	ding I J. After funer	tion:	27. Manner of Deatl	n 5 ☐ Pending investigation	28a. Date of Injur (Month, Day	(Year)	28b. Time of Injury	' _M	28c. Injury a Work? 1 □ ∨a	at es 2∐No	28d. Describe h	now injury	occurred			
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7	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi	Medical Co	29a. Certifier (Check only one)		ysician: To the best on niner: On the basis of and manner sta	examinati)
	To thi within To the compl	Me	29b. Signature and					29	c. License	number			signed (Mo			
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Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

JAN 0 7 2010

32. Registrar's Signature

10-00042 Rosa Johnson Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

sa Johnson		State of Maryland / Department of Certificate of		2010 012							
Physic	ian/	1. Decedent's Name (First, Middle,Last)		Reg. No. 2010 0 3 2. Date of Death Month Pay Year 3. Time of Death							
edical Exam	inei			January 2, 2010 Year 1736 hrs							
		4a. Facility Name (if not institution, give street and number) Washington Adventist Hospital	b. City, Town, or Location of Death Takoma Park	4c. County of Death Montgomery							
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs.	8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign South							
Director		247-66-2741 1_M 2XF 68 Yrs.	Months Days Hours Min.	April 26,1941 Country Caroli							
ń.		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	on	10d. Inside City Li							
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faryla 28a-f 1 at on	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?							
n with the Maryland ms 23a or 28a-f sho be notified at once.	直	3222 - 5th Street, S. E.	20032	United States							
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21 nould b nd Men is mar	[2	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing		ral Route Number, City or Town, State, Zip Code)							
MC and 2 sl salth ar em 27	8.0	Sharon Johnson Graham (Daughter) 4220 20a Method of Disposition 20b Place of Disposit		g George, Virginia 22485 Date 20c. Location - City or Town, State							
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		1 X Burial 2 Cremation 3 Removal from State crematory or other	er place) Jan.	16,2010							
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Ba perm Depa Imp				reet, N.W.; Washington, D.C. 2							
Physician		art I. Enter the disease, or complications that caused the death. Do not enter the failure. List only one cause on each line.									
/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	ovascular Disease	Death							
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Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death. The thin 24 hours after death. The this certificate has been signed by the attending physician and napletely filled in by the funeral director, page 2 should be detached for use as the burial - transit	a E	d.									
O, e be exi ysician burial -	edical	UNPENDED AMENDED	,								
Box 6876 cath certificate the attending phy of for use as the the		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Feta	al death 3 Ectopic pregnand	23d. Date of delivery Month Day Year							
OX 6 sath cer attend	sician/N		er (Specify)								
J. B. the de by the ached f	Phy	Part II. Other significant conditions contributing to death but not resulting in the un	derlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?							
P.O res that to signed b	d by	End stage renal disease, bacteremia		1 Yes 2 No 3 Probably 4 V Unknow							
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Che law rate has rage 2 s	mo d mo			performed? death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No							
tal Re(ian: The certificate ector, page	BeC	25. Was case referred to medical examiner?	26 Place of Death (Check on	ly one)							
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/iSic rr Atte ter des irrecto in by th	fical	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street,	, factory, office building, etc. 2	Bf. Location (Street and Number or Rural Route Number, C							
Div pital o ours af eral D	Certification:	4 Homicide determined (Specify)		or Town, State)							
To the Hos within 24 h To the Fun completely		29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurre one) 2 Medical Examiner: On the basis of examination and/or investigation									
To the within To the comple	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation and manner stated. 29b. Signature and title of certifier	29c. License number	29d Date signed (Month, Day, Year)							
	-	11/1 1 1/1 1/1	O.C.M.E.	January 3, 2010							
,		30. Name and address of person who completed cause of death (Item 23a)									
		Melissa Brassell, MD Assistant Medical Examiner 111 Pe	enn Street, Baltimore, MD 2	1201							
	tate										
Regis	utT	The Colo Contract to the									

OCME

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or 28a-f st	1	Maryland Carrol 10e. Street and Number		ľ	Moun	t Airy 10f. Zip Code				10g. C	itizen of W		
72 hours after death with the Maryland ratural", or items 23a or 28a-f show chail Evaminer must be notified at order by Fundral Director	5	1005 Westward 11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced	12. Was Decedent Armed Forces	? K No	S.	13. Was Decedent or If Yes, specify Cu		n? (Specit Puerto Ric	fy Yes or No can, etc.)	0-	14. Race	, White, e	an Indian, etc.
ed within 72 houygiene.		15. Decedent's (Specify only highest (Elementary/Secondary (0-12)	Education grade completed) College (1-4or	5+)	1	Decedent's Usual Occ Give kind of work don life. DO NOT use reti	e during most o red)	of working			Kind of Bus		•
tal Hygien d other th event, the		17. Father's Name (First, Middle, La	2			Secreta	18. Mother's	s Name (F	First, Middle	_			nment
should be and Ment is marked aumatic e	2	Robert V. 19a. Informant's Name/Relationship	Bryant (Type. Print)		19b.	Mailing Address (Stre		or Rural F		onga ber, City		State, Zip	Code)
permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, In Michell Eag	-	Mary Anne Sirk - 20a. Method of Disposition 1	☐ Removal from State	9	Place of I cemetery	005 Westwa Disposition (Name of crematory or other p	lace)	Date	Э	20c. L	ocation - 0	City or To	wn, State
permit. Pa Departmer Important: any injury once.		4 □ Donation 5 □ Other (Spe 21. Signature of Funeral Service	cify)	- P:	rosp	ect Cemete 22. Name and Add Moleswor	Iress of Facility			1			Maryland ne
Physician /Medical Examiner un and initiality	>	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury) Due to (or as a consequence of): Due to (or as a consequence of):										·lanc	Approximate Interval Between Onset and Death Days
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w requires that the d		1 ☐ Yes 2 ☐ XNo 9 ☐ Unknown Part II. Other significant conditions	9 🗆 Unknown			5 ☐ Other (specify) the underlying cause (ne cause of death?
ican: The law require certificate has been sector, page 2 should							-		24a. Was auto perf	s an	24b. W	ere auto rior to cor eath?	psy findings available repletion of cause of
This later		25. Was case referred to medical examiner? 1 □ Yes 2 ☒ No 27. Manner of Death 1 ☒ Natural 5 □ Pending 2 □ Accident investigat	28a. Date of In (Month, D	jury	28b. Ti	me of ury 28c. In		sing Home	Check only 5 ☐ Res d. Describe	idence			у)
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To t vith		29b. Signature and title of certifier	2 NO				61410						Day, Year)
6		30. Name and address of person wh Gaffar Syed	, M.D. 801	l Tol	1 Ho	use Avenue		leric	k, Ma	ry1a	.nd	2170)1
State Registrar		31. Date filed (Month, Day, Year)	32. Regis	trads Signa	ature	A. park	1						

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Funeral

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show notified at

'natural", or items 23a or 28a-f

permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be a

Baltimore, Maryland 21215-0036

The law requires that the death certificate be executed and Records, P.O. Box 68760, the attending physician as the Division or Vital To the Hospital or Attending Physician:

21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 No Day 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Tyes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an perform 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 7949 30. Name and address of person wh death (Item 23a) (Type, Print) ompleted erest here Sut 2017, Westruty My) Alexand

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

24 hours after death. completely filled in by the

within 24

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			For State	State of	Maryland /	Departmen Certificat			nd Me	ental Hy		20	10	01386
			Registrar 1. Decedent's Name (First, Middle, La	ast)		Certificat	e or L	Jeani	2	. Date of De			10	3. Time of Death
	Physici /Medio			Chong Su	n Kim					Janua	ry 05	, 20 [°]	1 0	4:12 am
	Examin		4a. Facility Name (If not institution, gi			4b. City,		Location of			4c.	County of		
	F		Shady Grove Adv. 5. Social Security Number 6.		OSPITAL 7. Age (In yrs. last b	pirthday) If Under		Rockvi		. Date of Bi	irth			gomery ace (State or Foreign
	Funeral Director			1 □ M 2 💢 F	79	Yrs. Months	Days	Hours	Min.	(Month, D	ay, Year)		Count	Korea
	p ,		Usual Residence of Decedent		140 00 7				,,,,	1009 20	, ,,,			
	shov	'n	10a. State 10b. County		10c. City, To	wn or Location							10	od. Inside City Limits 1 ☐ Yes 2 ☑ No
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Z	d 2 sh Ith an Ith an Itaur	13	19a. Informant's Name/Relationship Leeanne Yi - Di		I .	9b. Mailing Address								_{code)} inia 20147
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Baltimore,	rmit. spartm porta y inju		21. Signature of Funeral Service Lice		200	22. Name ar	nd Addres	s of Facility	Hine	s-Rin	aldi	Fune	ral	Home, Inc.
8	9 9 E 6 9		1 alay	Ware	- 440	11800	New t	Hampsh	ire.	Ave.,	Silv	er S	prin	g, MD 2090
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Division of Vital Records,	ing Phys n. After this funeral di	Certification: To	27. Manner of Death	1	-		8c. Injury Work	1 - 11011		e 5 🗆 Res d. Describe)
io	ending lath.	atio	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	on	i, Day, rear)	Injury M		.? Yes 2 □ N	0					
Ξ	or Attu	ığ l	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of building	of Injury - At home, g, etc. (Specify)	farm, street, factory	, office		28	f. Location (City or To	(Street and wn, State)	Number	or Rural	Route Number,
Ω	Hospital of the hours at Funeral D rely filled i		29a. Certifier 1 Certifying P	bysisian. To the	best of my knowled		-		1 = 1 = = = = = =	-1 -1 - 2 - 31				
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical	(Check only one) 2 Medical Exa	miner: On the ba	sis of examination a	ge, death occurred and/or investigation	in my or	ne, date and pinion, death	n occurred	at the time	e cause(s) , date and	place, and	ner as st d due to	ated. the cause(s)
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			1XW	1)	<		DO	006450	12		Janu	ary (05.	2010
	S	Ť	30. Name and address of person who		of ath (Item 23a) (Type, Print)	-			*				
	Sta		Brian Carpenter, 31. Date filed (Month, Day, Year)		901 Medic		r Dr	ive, F	Rocku	ille,	Mary	land	208	50

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible State of Maryland / Department of Health and Mental Hygiene 4 U Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 5.15 AM 2010 10 0 /Medical 4a. Facility Name (If not institution, give street and number, 4c. County of Death 4b. City. Town, or Location of Death Examiner Patuxent River Health & Rehab. Laurel Prince George's | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Dec. 8, Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 6. Sex **Funeral** Months 1 □ M 2 🕱 F 089-16-5366 86 New York 1923 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Experience. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits x⊠Yes 2 No Director Maryland Prince George's Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 402 Compton Avenue 20707 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ∐Yes 2 XXXo Specify Specify: White XX Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Max Rein Celia Unknown ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Kanter/Son 402 Compton Avenue, Laurel, MD 20707 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan Crematory 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Jan. 2010 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Virginia Tranced Address of Sollins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Preumon _{.₃}Physician unknown disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) Physician: The law requires that the death certificate be executed burial-trar resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 9 ☐ Unknown in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s autopsy this certificate 2 ZiNo 1 ☐ Yes 2 ☐ No 1 TYes the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

P.O. Box 68760, Division of Vital Records, spital or Attending Particular of the state within 24 hours a To the Funeral D Hospital

29b. Signature and title of certifier ewan. MD

29c. License number 00 6253

🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year) 2010 0

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHIAWAN

9055 Cheriolet Dr. Sule 103, ElliCott City, MD-21042

State Registrar

Medical

29a. Certifier

(Check only

31. Date filed (Month, Day, Year) 2010 JAN 06



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar - Pertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 13, 2010 January 3:25p^M Joyce M. Kershner /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cecil 118 Hearthstone Drive E1kton 8. Date of Birth (Month, Day, Year Feb. 20, 19 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🙀 F Months Days Hours Min. 81 Director 210-18-8236 1928 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County d other than "natural", or items 23a or 28a-f show event, the Modical Evaminer must be notified at Director 1 ☐ Yes 2 ☑ No MD Ceci1 E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 118 Hearthstone Dr. 21921 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: White þ 3 ¥ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 7 is marked other traumatic event. If f Health and Mental Hvert is man 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Ziegenfus ၉ Edith Sebring 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and Department of Health Important: If Item 27 any injury or other tr once. Sarah Drummonds/ daughter 118 Hearthstone Dr. Elkton, MD 21921 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1/16/2010 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Zion Stone Church Cemetery New Ringgold, PA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility R.T. Foard and Gee 259 E. Main St. Elkten, MD 21921 me cause on each line. win 23a. Part 1. Enter n e disease, or com shock, or hart fallure. List o Immediate Cause (Final Approximate Interval Between Onset and Death Physician 5 disease or condition resulting in death) /Medical Due to (or as a nsequence of): Examiner Sequentially list conditions, if any leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last (to consignation of air Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trans Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) 9 Unknown cate has been signed by page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 🗷 No certificate 2 No 1 ☐ Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Na Residence 6 Other (Specify) 1 ☐ Yes 2 📉 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day, Year) After t 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 | Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation hours after death uneral Director; 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

Division of Vital Records, P.O. Box 68760, completely filled in by the Hospital within 24 hours a

> 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) MD 32. Registrar's Sig

State Registrar

0

29b. Signature and title of certifier

MO

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 01389 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January 2, 2010 2010 1421 Kirby Margaret S. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Montgomery Holy Cross Hospital Silver Spring 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 🕱 F Months Hours Min. Director Yrs. 579-34-0770 84 Washington, DC Usual Residence of Decedent ital Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. inside City Limits Director 1 XYes 2 No Maryland Montgomery Kensington 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral United States 10225 Frederick Avenue 20895 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 K Married Š If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Specify: 3 Divorced 4 Divorced White Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Montgomery County Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental H is marked of permit. Page 1 and 2 should be . Department of Health and Mental. Important: If item 27 is merany injury or other. ဂ္ Elmer John Love Shane Addie Durham Goode 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10225 Frederick Avenue #405 Kensington, MD 20895 Edward C. Kirby/ husband 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗌 Burial 2 🕱 Cremation 3 🗌 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Journey Crematory 1/7/2010 Woodbine, Maryland 21. Signa re of Funeral Service Licensee GoThgrade for the control of the con P.O. Box 784 Thomas M00957 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Partyl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final *Physician/ disease or condition resulting in death) Atherosclerotic Cardiovascular Disease Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of): physician and the burial-transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical attending ph IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☒No
9 ☐ Unknown Year Day Pregnant at time of death been signed by the should be detached g | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed? this certificate 2 No Yes 2 🔀 No 1 Yes After this certification funeral director, p 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 **X**No ၉ 1 Yes 1 Inpatient 2 X ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Hospital or Attending Natural 5 Pending 1 Yes 2 No Accident Investigation Funeral Director: , sted filled in by the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier critifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Sign 29c, License number 29d. Date signed (Month. Dav. Year)

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

State

Registrar DHMH 17 Rev 7/2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LIMAN

Registrar's Signature

Steven

31. Date filed (Month

D24348

1500 Forest Glen Road Silver Spring, MD 20910

1.05.2010

Registrar DHMH 17 Rev 1/2001 31. Date filed (Month, Day,

Year) JAN 0

Registrar

JAN 08

Baltimore, Maryland 21215-0036

Box 68760.

P.O. |

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ -Month 26/0 Lea Long Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 54h56U14 Regionar VICOMICO enin such If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛛 F (Month, Day, Year) 2-6-1939 Country) Maryland 215-36-1494 Director 70 Usual Residence of Decedent 10a. State 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director ms 23a or 28a-f s must be notified 1 X Yes 2 No MD Wicomico Fruitland 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 505 Clyde Avenue 21826 USA ural", or items? 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 🔯 No Yes, Give Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify. White "natural". Specify: Completed 3 X Widowed 4 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clayton Adkins Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alan Long - Son 8110 Esham Road, Parsonsburg Maryland Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Creamatory of Delmarva 1-9-2010 Delmar, Delaware Signature of Funeral Service L 22. Name and Address of Facility Bounds Funeral Home 1150 Street, Salisbury, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Due to (or as a consequence of): disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying or Attending Physician: The law requires that the death certificate be executed Cause (Disease or imjury that initiated events and burial-trar Due to (or as a consequence of): resulting in death) Last the attending physician the dor use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Year Pregnant at time of death detached 9 Unknown has been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobaccouse contribute to the cause of death? Completed by page 2 should be 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? COPS within 24 hours after death.

To the Funeral Director, After this certificate 1 Yes 2 No the funeral director, 25. Was case referred to me Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗆 Yes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27, Manner eath 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred atural (Month, Day, Year) 5 Pending work? 1 Yes 2 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) Signature and title of certifie 29d. Date signed (Month, Day, Year) 29b 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Rosemary Catherine Lawrence 10:10 PM 2010 January Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince George's Villa Rosa Nursing Home Mitchellville Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Days (Month, Day, Year) 1ay 2, 1924 1 M 2 X F Months Hours Min. 578-24-2838 Director 85 Washington, DC May Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10c, City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No Maryland Prince George's Laure1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7703 Beall Road 20707 USA within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc þ 1 Never Married 2 Married 1 ☐ Yes 2 🖾 No If Yes, Give Year or Dates 1 ☐ Yes 2 🛛 No Specify: Specify: White Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 tal Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker 12 Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any prianty or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Rose Weber Raymond Bligh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John B. Lawrence / Son 7703 Beall Road, Laurel, MD 20707 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Mount Olivet Cemetery 1/8/2010 Washington, DC 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue RAY ROGERS Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line, Immediate Cause (Final Physician/ Cardiomyopathy disease or condition resulting in death) <u>Years</u> Medical Due to (or as a consequence of): Examiner Years Chronic Kidney Disease Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): Exami or Attending Physician: The law requires that the death certificate be executed burial-transi Hypertensive Cardiovascular Disease Years that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical the 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☒ No Pregnant at time of death 5 Other (specify) Month Day Year ned by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ sign. be c Dementia 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 N 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 🖾 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) မ 2 🛛 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 24 hours after death. Funeral Director: After 1 X Natural 5 Pending 1 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation Could not be the 1 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined To the Hospital o within 24 hours af To the Funeral Di Medical 1 🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 🗌 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier соmpleted 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 5 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

Date filed (Month, Day, Year)

JAN 0 7 2010

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Records,

of Vital

Division

Rakesh Arora, 14300 Gallant Fox Lane, Suite #222, Bowie, MD 20715

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Henry Leahy, Jr. State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar Certificate of Death Reg. No. 2010										
Physician/ Medical Examine	1, Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year									
All LXamme	Henry S. Leany, Jr. 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death									
	7317 Willow Glen Way Elkridge Howard									
Funeral Director	5. Social Security Number 215-68-8509 1 M 2 F 7. Age (In yrs. last birthday) 17. Age (In yrs. last birthday) 18. Days Hours Min. June 2, 1952 Washington, DC									
any	Usual Residence of Decedent 10a. State									
.	Maryland Howard Elkridge									
the Maryland a nr 28a-f sh tiffed at nace	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?									
th the N 23a ur notified	7317 Willow Glen Way 21075 USA									
r death with or items 23, c. must be not	11. Marital Status 12. Was Decedent Ever in U.S. 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 8lack, White, etc.									
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hours fratur Exami	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) College (1-4 or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of 8usiness/Industry									
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. Inter of Health and Mental Hygiene. Inter 17 is marked rither than "natural", or items 23a nr 28a-f show or rither traumatic event, the Medical Examiner must be notified at nace. To Be Completed by Funeral Director	Draftsman Architectural									
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medical TO BE COMPILE.										
212 tould be id Ment is mark	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)									
MD and 2 sho salth and 2 sistem 27 is	Suzanne Meier / Sister 709 Park Avenue, Baltimore, MD 21201 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State									
TOFE, start of He inther the	1 X Burial 2 Cremation 3 Removal from State crematory or other place) Fort Lincoln Comptons 1/7/2010 Report visual and									
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite	21. St. mature of Funeral Service Licensee 22. Name and Address of Facility 23. St. mature of Funeral Service Licensee 24. St. mature of Funeral Service Licensee 25. Name and Address of Facility 47.39 Baltimore Ave.									
	Gasch's Funeral Home, P.A. Hyattsville, MD 20781									
Physician /Medical	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Atherosclerotic Cardiovas cular Disease.									
taminer	Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic Cardiovascular Disease Due to (or as a consequence of):									
9	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):									
ted Insit Examine	eausc. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):									
50, te be executed sysician and burial - transit	d.									
O, e be executed ysician and burial - transi	UNPENDED AMENDED									
3876 rtificate ing phy as the l	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 23d. Date of delivery Month Day Year									
). Box 6876, the death certificate by the attending phy ched for use as the by Physician/M.	1 Yes 2 No 9 Unknown 9 Unknown 9 Unknown									
ords, P.O. Be wrequires that the d s been signed by the should be detached	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?									
Records, P.O. The law requires that the fireate has been signed by, page 2 should be detaal. Completed by F.	Viral Syndrome; Obesity; Diabetes mellitus 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown									
cord law req has bee	24b. Were autopsy findings available autopsy prior to completion of cause of performed?									
tal Rec cian: The l certificate l ector, page	1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one)									
Vital ysician this cert directo	examiner? 1 ✓ Yes 2 No No No No No No No No									
Division of Vital Records, tal or Attending Physician: The law require rs after death. In Directur: After this certificate has been sited in by the funeral director, page 2 should be striffication: To Be Completed	27. Manner of Death 1 V Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No									
ivision or Atten after death Director: In by the	2 Accident Investigation 28e Place of Injury - At home farm street factory office building etc. 28f Location (Street and Number of Pural Poute Number City.									
Division o spital or Attending tours after death. neral Director: After filled in by the function of the func	4 Homicide Could not be determined (Specify)									
Division of Vital Records, P.O. Box 68766 To the Bospital or Attending Physician: The law requires that the death certificate within 24 hours after death. The the Funcral Directur: After this certificate has been signed by the attending phy completely filled in by the funcral director, page 2 should be detached for use as the beneficial Certification: To Be Completed by Physician/Me	22a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) mel Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)									
To with	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)									
	Caude Hellau O.C.M.E. January 5, 2010									
R3	30. Name and address of person who completed cause of death (item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201									
State Registra										
Registral	A : PAIA PAIA - - - - - - - - -									

DHMH 17 Rev 1/2001 OCME 2006

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2010 1615 January SmithLawrence Medical Maude 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death St. Mary's St. Mary's Nursing Center Leonardtown Social Security Number If Under 1 Year If Under 24 Hrs . Age (In yrs. last birthday) 8. Date of Birth g. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕅 F Country) Maryland Months Days Hours 01/01/1914 Director 579**-**30-7271 Usual Residence of Decedent show 10b. County ms 23a or 28a-f shormust be notified at 10a. State 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director 1 Yes 2 X No Maryland | St. Mary's Hollywood 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 24669 Hollywood Road 20636 United States ral", or items? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married Yes 2 X No within 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: "natural" Completed 3 Widowed 4 Divorced White Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working if Health and Mental Hygiene. item 27 is marked other than other traumatic event, the Me life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Secretary Lumber Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Page 1 and 2 should be Umphrey Winfield Smith Lydia Maude Dean 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joanne Buzzell/Daughter 24665 Hollywood Road, Hollywood, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date to I 1 X Burial 2 Cremation 3 Removal from State Department of Important: If any injury or once. 4 Donation 5 Other (Specify) 01/13/2010 | Hollywood, Maryland Chapel Cemetery Paneral Service 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Edward N. Brinsfield 22955 Hollywood Rd., Leonardtown, MD 20650 M00052 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approxii. Interval B weei. Onset a eath shock, or heart failure. List only one cause on each Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine attending physician and for use as the burial-transit that initiated events resulting in death) Last Physician/Medical certificate be P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) Live Birth 2 Fetal death in the past 12 months? Pregnant at time of death Month Day Year ed by the a detached for 1 Yes 2 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. this certificate has been signed al director, page 2 should be de 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 ☐ Yes 2 M No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an performed death? Yes 2 No To the Hospital or Attending Physician: 'within 24 hours after death.

To the Funeral Director: After this certific, completed filled in by the funeral director, I Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes Other: 2 No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 👰 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 29d. Date signed (Month, Day, Year) MIX cause of death (Item 23a) (Type, Print) 30. Name and address

Registrar
DHMH 17 Rev 7/2009

Pat

rick

Jarboe

M.D.

32. Registrar's Signature

24035 Three Notch Rd., Hollywood, MD 20636

			Pleas	se Type or Pr							•	
			1 - For State Registrar	State of N	/larylan		artment of I rtificate of		and Mental H	lygler Reg.1	0010	01396
	Physici	on	1. Decedent's Name (First, Middle	, Last)					2. Date of Month		Day Year	3. Time of Death
	/Medi			Mary Eliza		Lively			Janua	ry	13 2010	1450 P ^M
1	Examir	ner	4a. Facility Name (If not institution		er)		4b. City, Town, o		f Death	4	4c. County of Death	1
É	Francis		144 Laurel Run 5. Social Security Number		Age (In vrs. I	ast hirthday)	E1kto		24 Hrs. 8. Date of	Birth	Cecil	nplace (State or Foreign
	Funeral Director		232-48-7003	1 🗆 M 2 🕅 E	75	Yrs.	Months Days	Hours	Min. (Month, DEC 16	Day, Yea	ar) Cou	st Virginia
	pu. w		Usual Residence of Decedent 10a, State 10b, County			. Town on La	anting					10d. Inside City Limits
	laryla i shov	ō	,	1		, Town or Lo	cation					1 ☐ Yes 2 ☑ No
	the N	Director	Maryland Ceci		E	1kton	10f. Zip Code			10g.	Citizen of What Cou	44
	h with 23a ol st be	a D	144 Laurel Run	Road			2192	1			United S	States
	ems a	Funeral	11. Marital Status	12. Was Deceder Armed Force	nt Ever in U.S	3. 13.	Was Decedent of I	Hispanic Orio	gin? (Specify Yes or , Puerto Rican, etc.)	No-	14. Race - Amer	ican Indian,
36	or it	by Fi	1 ☐ Never Married 2 💢 Marri	ed 1 ☐ Yes 2 💆 If Yes, Give	No		1 □Yes 2 No		, , , , , , , , , , , , , , , , , , , ,		Specify:	
9	houn tural	ed b	3 ☐ Widowed 4 ☐ Divorced 15. Decedent	Year or Dates	s: 	16a. Dece	dent's Usual Occu	nation		16b	Kind of Business/l	hite ndustry
21215-0036	thin 72 hours after death with the Marylan e. an "natural", or items 23a or 28a-f show Medical Examinet must be notified at	plet	(Specify only highes	t grade completed) College (1-4o	r 5+)	(Give	kind of work done DO NOT use retire	during most	of working			,
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Maryland	d d d	Be	17. Father's Name (First, Middle, L						r's Name (First, Midd		len Surname)	
ry	2 should and Me is mark aumatic	မ	George Longheni 19a. Informant's Name/Relationsh	-		19h Mailir	nn Address (Street		e Stickle: or or Rural Route Nur		tv ar Tawn State 7	in Cade)
≥	s 1 and 2 should f Health and Mer item 27 is marke other traumatic		Rodney R. Live			I	•		d, Elkton			ip code)
ore,	es 1 and 2 of Health of item 27 is r other tra		20a. Method of Disposition		20b. Pl		sition (Name of natory or other pla	1	anuary 17	20c.	Location - City or T	own, State
Ē	Page ment ant: It ury o		1 🕅 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		e	Galena	Cemetery	y 2	010		Galena,	MD
Baltimore,	permit. Pages 'Department of Important: If ite any Injury or of once.		21. Signal are of Funeral Service L	icensee		Hi	Name and Address Home	ess of Facility	unerals,	P.A.		
	TO = 8 0		220 Port 1 Enter the discourse or	& Deck	O death	- 110)3 W. Sto	ckton	Street, E	Ikto	on, MD 2	1921
E	Physician		23a. Part 1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final	only one cause on each	line.	l. Do not em	er the mode of dy	ng, such as	cardiac or respiratory	y arrest,	1	Approximate Interval Between Onset and Death
3	/Medical		disease or condition resulting in death)	a. Due to (or a	is a consequ	ence of):						
	Examiner	_	Sequentially list conditions,	b. Hype	RAEN	SION						
	bed sit	ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	is a consequ	rence of).						
_,	eath certificate be executed attending physician and for use as the burial-transit	zaminer	that initiated events resulting in death) Last	c Due to (or a	ıs a consequ	ence of):						
68760	siciar ysiciar e buri			d.								
89	death certificate be e attending physicia d for use as the bur	Physician/Medical	IF FEMALE:									
Вох	ath ce ttendi or use	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom	2 Fetal	death 3	Ectopic pregnan	су			23d. Date of deli Month	very Day Year
	0 0	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant 9 ☐ Unknowr		eath 5	Other (specify) _			-	Wichter	bay rour
	law requires that the as been signed by th 2 should be detache		Part II. Other significant conditio	ns contributing to death	but not resu	Iting in the u	nderlying cause gi	ven in Part I.	23e. Di	d tobacc	o use contribute to	the cause of death?
Records,	w requires been sig should be	ed by							1[⊒ Yes	2 No 3 Pro	obably 4 🗌 Unknown
ဝ၁	e law requ has been e 2 should	Completed							24a. W	as an topsy	24b. Were aut	topsy findings available ompletion of cause of
<u>~</u>	Th ate	Com							pe 1 □ Ye:	rformed?	? death?	2 No
Vits	Physician: The la r this certificate ha ral director, page 2	Be	25. Was case referred to medical examiner?	Hospital:			011		of Death (Check onl			
ō	_ + ₽	٥-	1 Yes 2 Ø No 27. Mann f Death	1 ∐ Inpa 28a. Date of Ir	njury	ER/Outpatier 28b. Time of	nt 3 □ DOA □		rsing Home 5 X Re		6 ☐Other (Spec	eify)
<u>io</u>	nding Fath. r: After re funer	atio	1 Vatural 5 Pending 2 Accident investig		Day, Year)	Injury	Wo	rḱ?]Yes 2.∐N				
Division of Vital	ir Atte ter deα irecto irecto	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	28e. Place of I	njury - At hor etc. <i>(Specify</i>	me, farm, str	eet, factory, office	-	28f. Location City or 7	(Street Town, Sta	and Number or Ru ate)	ral Route Number,
	pital c		29a. Certifier 1 Lecrtifying	Physician: To the bes	et of my know	Lean anhalv	h occurred at the t	ime date an	d place, and due to t	be cause	o(s) and manner as	stated
2	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical	(Check only 2 Medical E	xaminer: On the basis	of examinat	ion and/or in	vestigation, in my	opinion, deat	th occurred at the tim	ne, date a	and place, and due	to the cause(s)
	Voin Con	2	29b. Signature and title of certifier	1.10	1. 5		29c. Licens	6340	P	29d. I	Date signed (Month	, Day, Year)
			30. Name and address of person v	the completed cause of	death (ffem	23a) (Tunc	Print\				01/17	110
			VANESSA VILL		361	FAIR	HILL DY	e. E	LKTON, M	D	21921	
	Sta	te	31. Date filed (Month, Day, Year)	32. Regis	trar's Signat	_						

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 01397 State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 197709/2870 1253 Ralph Ellis Moody, Ir. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death
Baltimore Stella Maris Timonium 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 🛛 M 2 🗆 F 67 Months Days Hours Min 0993077 942 215-40-5084 MaSerryand Director Usual Residence of Decedent Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c, City, Town or Location Havre de Grace 10a. State 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director Maryland Harbord 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? United States of America Completed by Funeral 21078 116 Francis Street 12. Was Decedent Ever in U.S. Armed Forces?

1

Yes 2 □ No

If Yes, Give 1964-7 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 1 X Yes 2 No If Yes, Give 1964-70 Year or Dates. If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 X Married 21215-0036 White 1 ☐ Yes 2 💢 No Specify: 3 🗆 Widowed 4 🗆 Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Civil Service Contracting Officer Representative Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) HELEN MCLEL 2 Ralph Ellis Moody 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Nymber City or Town, State, Zip Code) 116 Francis Sireci, Havne de Grace, Maryland 21078 Carole R. Moody (wife) 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State RA Ferusaco, inc. 1
Burial 2
Cremation 3
Removal from State WestChester, Pennsylvania 01/12/2010 4 ☐ Donation 5 ☐ Other (Specify) Signature of Bone 22. Name and Address of Facility Zellman Funeral Home, P.A. 21078 123 S Washington St. Havre de Grace, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) ESOPHAGEAL CANCER Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease of linjury within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No 4 Pregnant Pregnant at time of death Month Day Year 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6\(\mathbf{X}\) Other (Specify) 2 X No 은 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA HOSPICE Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work? 1 Yes 2 No 1 X Natural 5 Pending Accident Investigation 2 ☐ Acciden 3 ☐ Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Territoring Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) 2010 off person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 JACKIE JONES, CRNP State

Registrar

12:53 р.ш.

2010

ANUARY

RAL.PH MOODY

10-00125 Darrin Leslie Mc	Gilv	Please Type or Print in Black Indelible Ink. Ensure All Copie State of Maryland / Department of Health and Mental H	es Are Leg ygiene	ible 2010	01398				
		1- For State Certificate of Death Registrar		j. No.					
Physicia Medical Exami		1. Decedent's Name (First, Middle, Last) Darrin L. McGilvery	2. Date of Death Month January 5,	Day Year	3. Time of Death 0342 hrs				
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 7105 East Spring Street Landover	1	4c. County of Death Prince George					
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs Months Days Hours Min		(MM/DD/YYYY) 9. Bird Foreig 28, 1962 Col					
d 10w any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits 1 X Yes 2 No				
e Marylan or 28a-f sl	Director	DC Washington 10e. Street and Number 10f. Zip Code	100	g. Citizen of What Cour	atry?				
th with the ems 23a ct be notif	Funeral D	4410 Gault Place NE 11. Marital Status 1 X Never Married 2 Married Armed Forces? 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Sp. 13. Was Decedent of Hispanic Origin? (Sp. 14. Was Decedent of Hispanic Origin?)		United S 14. Race - Ameri White, etc.					
Baltimore, MD 21215-0036 Searnit, Pages I and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show, injury or other traumatic event, the Medical Examiner must be notified at once.	by Fur	1 Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Year or Dates: 1 Yes 2 X No specify:		Opcomy.	ack				
6 n 72 hours an "natu ical Exan	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 1 2 - 1.	red)	16b. Kind of Business/h	ndustry				
-003 I withi giene. ther th	E	12th Home Improvement Special Representation of the Improvement Special Representation Special Representation Representation Special Representation Representation Representation Representation Representation Representation Representation Representation Representation Representation Representation Representation Representation Representation Representation Representation Representation Representation Repre		Self-Emp	oloyed				
21215. Id be filec Mental Hy narked of	o Be C	1	ristine l	E. Little	Zin Code)				
MD 2 nd 2 shou ulth and M m 27 is n	٩	Shelvia L. McGilvery/ Sister 805 Glacier Ave. Cap	itol Hei	ghts, Md.	20743				
nore, ages I ar nut of Hee nt: If ite			uary 14, 2010	20c. Location - City or Suitland,					
Baltin permit. P Departme Importar injury or	ij	4 Donation 5 Other Specify: Washington National 1. Signature of Properal Service License 22. Name and Address of Facility Storage 4001 Benning Rd. 1	ewart Fu	neral Home	Inc.				
Physician /Medical		23a. Par I. Enter the discusse, or combinations that caused the four Park History the mode of dying, such as cardiac of illure. List only one cause on each line.			20019 Approximate Interval Between Onset and				
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Gunshot Wounds (2) of Head Due to (or as a consequence of):			Death				
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated							
executed an and al - transit	Exar	events resulting in death) Last Due to (or as a consequence of): d.							
an exe	ledical	UNPENDED AMENDED IF FEMALE: 23c. If yes, outcome of pregnancy		22d Date of delivery	_				
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicia completely filled in by the funeral director, page 2 should be detached for use as the buria	Physician/Medi	25c. If yes, outcome of pregnancy 1	ancy	23d. Date of delivery Month D	ay Year				
ords, P.O. wrequires that the as been signed by the should be detached.	Ď	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		acco use contribute to t					
Records The law requi	Completed	24a. Was an autopsy prior to comperformed? 1 ✓ Yes 2 No 1 ✓ Yes							
Vital Rec hysician: The this certificate	Be	25. Was case referred to medical examiner?	only one)						
Vit	일	1 Yes 2 No Inospiral 1 Inpatient 2 ER/Outpatient 3 DOA Outel 4 Nursin	The second second	esidence 6 🗸 Other:	Scene				
ion of trending Ph. leath. tor: After true funeral		27. Manner of Death 28a. Date of Injury 1 Natural 5 Pending 2 Accident Investigation 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? FOUND: Jan 5, 2010 28b. Time of Injury 28c. Injury at Work? FOUND: 0337 hrs	28d. Describe ho Subject shot	w injury occurred					
Divisior ospital or Attend hours after death uneral Director:	Certification:	3 Suicide 6 Could not be determined Coperation Suicide A ✓ Homicide Could not be determined Coperation Suicide A Could not be determined Coperation Suicide Coperation Suicide A Could not be determined Coperation Suicide A Could not be determined Coperation Suicide A Coperation Sui	or Town, Sta	eet and Number or Rur te) ig Street , Landover					
To the Hospital within 24 hours To the Funeral completely fille	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred a and manner stated							
	ž	29b. Signature and title of certifier (10 C.M.E. 29c. License number O.C.M.E.		29d Date signed (Mon January 5, 2010	th, Day,Year)				
R2		30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 2120	1						
St Regist	_	31. Date filed (Month, Day, Year) S2. Registrar's Signature S. March							

DHMH 17 Rev 1/2001 OCME 2006

OCME

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month iseza-12:55 PM 10005h 26 **Physician** 2010) GANGY /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner **Baltimore City** The Johns Hopkins Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Yrs. 55 March 27, 1954 Iran Director 223-15-2535 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location or items 23a or 28a-f show miner must be notified at 1 ☐ Yes 2 X No Director Anne Arundel Annapolis Maryland 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number 21403 USA 36 East Lake Dr. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner once. 1 Never Married 2 Married 1 ☐ Yes 2 If Yes, Give Year or Dates Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Caucasian þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Chief Technology Officer Telecommunications 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Reza Mahmoodshahi Nosrat Maghdoni ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Wife 36 East Lake Dr. Annapolis, Maryland 21403 Narges Abrizah 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arnon Cemetery 1/11/2010 Great Falls, Virginia 21. Signature of Funeral Service License 22. Name and Address of Facility Murphy Funeral Home 1102 W. Broad St. Falls Church, Virginia 22046 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause Immediate Cause (Final disease or condition Theumonia **Physician** /Medical resulting in death) Examiner Sequentially list conditions flam, leading to immediate cause. Enter Underlying Cause (Disease or injury Cholangiocarcinona requires that the death certificate be executed that initiated events resulting in death) Last as the burial-trar by the attending physician Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death
Pregnant at time of death 3 - Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 2 No Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 🗌 Yes 3 Probably 4 Unknown has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 🗌 Yes 2 🗌 No 1 🗌 Yes this certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 1 Yes 2 No Hospital: 1 Inpatient 3 🗆 DOA 4
Nursing Home 6 ☐ Other (Specify) 2 ER/Outpatient 5 Residence မ 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Injury 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier RE5-000 Gutteeman 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287 GATHECHA 31. Date filed (Month, Day, Year) State JAN 1 1 2010 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** ROSALIE MACKO \mathbf{A}^{M} MARY 0445 03 2010 /Medical January_ 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** WORCESTER BERLIN NURSING & REHABILITATION CTR. BERLIN Birthplace (State or Foreign Country) 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Days Hours 1 □ M 2 🖾 F 85 APRIL 30, MARYLAND 1924 216-16-3896 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director DELAWARE SUSSEX SELBYVILLE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 19975 USA 37670 E. SHADY DRIVE Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 XYes 2 No If Yes, Give Year or Dates: 1944-46 1 Never Married 2 Married 1 □Yes 2XXNo ģ Specify: 3XXWidowed 4 □ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) WAITRESS RESTAURANT 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be NELSON APPLEGARTH LILLIE FRANK ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 38179 ROCK ELM DR., SELBYVILLE, DE. 19975 DIANA M. TURNER/NIECE 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 1/4/2010 CREMATORY OF DELMARVA DELMAR, DELAWARE 21. Sign fore of Funeral Service License 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 23a. Part 1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) snea Due to (or as a consequence of): Dh4919 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): DIFACTOR Breumonia Due to (or as a consequence of): Physician/Medical IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year

Physician /Medical Examiner

> and burial-trar

> > nse

for

page 2 should

director,

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

2

Be Completed

Certification: To

Hospital or Attending Physician: The law requires that the death certificate be executed

Box 68760.

P.O.

Records,

Division of Vital

permit. Pages 1 and 2 s Department of Health at Important: If item 27 is any injury or other trau

Funeral

Director

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

, o.

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int If them 27 is marked other than "natural", or items 23a or 28a-f show

Baltimark Maryland 21215-0036

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 9 Hinknown

5 ☐ Other (specify)

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. michie

worde

23e. Did tobacco use contribute to the cause of death? 1 des 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed? Yes 2,21No 1 ☐ Yes

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

mxreto 25. Was case referred to medical examiner? 1 Yes 2 No

1 ☐ Yes 2 ☐ No

. Manner of Death 1 Natural 5 Pending 2 Accident

6 Could not be determined

28a. Date of Injury (Month, Day, Year) investigation

1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Injury at Work? 1 ☐Yes 2 ☐ No

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a, Certifier (Check only one)

3 Suicide

4 Homicide

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number 1006925 29d. Date signed (Month, Day, Year)

Registrar

AVIL

31. Date filed (Month, 5

the Hospital or Attending Physician: The law requires that the death certificate be executed
hin 24 hours after death.
the Funeral Director: After this certificate has been signed by the attending physician and
mpletely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Funer	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U.S Armed Forces? 1 □ Yes 2 X No		Hispanic Origin? (Spectan, Mexican, Puerto R	cify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.						
d by	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 □Yes 24⊡ No			Specify: white						
Completed	15. Decedent's E (Specify only highest gr. Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+)	16a. Decedent's Usual Occu (Give kind of work done life. DO NOT use retire	during most of working	g	16b. Kind of Business/Industry Medical						
8	17. Father's Name (First, Middle, Last	2	Nurse	18 Mother's Name	(First, Middle, Maide	en Surname)						
To Be	David B. Ives	,		Helen Bo		,						
	19a. Informant's Name/Relationship		19b. Mailing Address (Stree									
	Colin McLaughl		6766 Atlant lace of Disposition (Name of emetery, crematory or other pla			d, DE 19973						
once. To Be Completed by Funer	20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	- 1	Location - City or Town, State Millsboro, DE									
ouce	21. Signature of Fune di Service decensee 22. Name and Address of Facility Cranston Funeral Home P O Box 967, Seaford, DE 19973											
an	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition	oplications that caused the death one cause on each line.	. Do not enter the mode of dy			Approximate Interval Between Onset and Death						
al	resulting in death)	Due to (or as a consequ	uen e ofr.									
er _	Sequentially list conditions,	b. ASC1										
Examiner	Cause (Disease or injury											
Exan	Cause (Disease or injury that initiated events resulting in death) Last c. Ton Credition Due to (or as a consequence of):											
	d											
Medi	TE STANKS											
by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 9 Unknown 23d. Date of deliving the pregnancy 23d. Date of deliving the pregnanc											
d by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death but not resulting in the underlying cause given in Part I.											
Completed				24a. Was an autopsy performed? death?								
	25. Was case referred to medical	T		OC Place of Dooth	1 □ Yes 2 No 1 □ Yes 2 □ No							
o Be	examiner? 1 ☐ Yes 2 💌 No	Hospital:	ER/Outpatient 3 DOA		·	6 ☐ Other (Specify)						
fication: To	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, Year)	28b. Time of 28c. Inju		8d. Describe how in							
Satio	2 ☐ Accidentinvestigatio	n		☐Yes 2 ☐ No								
Sertific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined		me, farm, street, factory, office	29	8f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)						
Medical Certi	29a. Certifier (Check only one) 1 Certifying P 2 Medical Exa	hysician: To the best of my know miner: On the basis of examinat and manner stated.	wledge, death occurred at the tion and/or investigation, in my	time, date and place, a opinion, death occurre	and due to the cause ed at the time, date a	e(s) and manner as stated. and place, and due to the cause(s)						
M	29b. Signature and title of certifier	1 1	_	se number	29d. [Date signed (Month, Day, Year)						
	I Sold 1	1.1)	05	7952		01/03/2010						
	30. Name and address of person who Bahulak Das mi	completed cause of death (Item	23a) (Type, Print) 2011 St. SA ture	lichun. n	nd 210	201						
State	31. Date filed (Month, Day, Year)	32. Registrar's Signat	ture	isoury 11	14 018							
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			ORIGINAL									

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 9:37 AM Month Edward Everett Maynor Medical 4a. Facility Name (if not institution, give street and number, 4c. County of Death 4b. City, Town, or Location of Death Examiner OUSTA at Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1 → M 2 □ F Months Hours Min. Country) 85 241-22-9753 Director North <u>/24/1924</u> Carolina Usual Residence of Decedent or items 23a or 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f show 10b. County 10c. City, Town or Location injury or other traumatic event, the Medical Examiner must be notified at Director 10d. Inside City Limits Willards 1 X Yes 2 No Maryland Wicomico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21874 36201 Richland Road 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 K No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. Black, White, etc Completed by 1 X Never Married 2 Married EVER H / Ilaynur Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: If Yes, Give Specify: American Indian 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) bridge crane operator Strescon Industries Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Ennis Balkins Maynor Lonnie Goodman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 36201 Richland Rd. Willards, MD 21874 Teresa Zlotorzynski/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 🔀 Buriai 2 🗆 Cremation 3 🗆 Removal from State Greenwood Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 1/9/10 Dunn, NC Name and Address of Facility Holloway Funeral Home Professional Association -CFSP Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final CANCAR Physician/ MRTASTATIC ROSTATR disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) • Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
• Funeral Director: After this certificate has been signed by the attending physician and been signed by the attending physician and should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day 4 Pregnant 9 Unknown Pregnant at time of death 5 Other (specify) 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 21 No 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1
Yes 2 24a. Was an the funeral director, page 2 autopsy performe 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital Other: 욘 HOSPICAZ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manney of Death Certificate: 28b. Time of 28c. Iniury at 28d. Describe how injury occurred injury work? Natural 5 Pending 2 🗌 No Accident Investigation 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 only one) 29b, Signature and title of certifie 29d, Date signed (Month, Day, Year) 00058410

Registrar

ROX

gistrar's Signature

21802

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WARE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death JAN. 1^{Day} 20⁴10 **Physician** ROBERT T. MURPHY 0527 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5413 Sharptown Road Dorchester Rhodesdale If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, May 24, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday Funeral Min 1 ★ M 2 □ F Months Days Hours 218-12-1666 89 May Delaware Director Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene.

m 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Neuflen Eveniment was the redflied at Rhodesdale 1 ☐ Yes 2 🛂 No Dorchester MD Directo 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code United States 21659 5413 Sharptown Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 **X**No White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: ģ Specify: 3x Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Automobile Mechanic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Fronia Murphy Alonzo Murphy ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health an
Important: If item 27 is
any injury or other trau
once. 5419 Eldorado-Sharptown Rd., Rhodesdale, MD 21659 Robert A. Murphy/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State 01/15/10 Eldorado, Maryland Eldorado Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Framptom Funeral Home, P.A. 216 N. Main St., Federalsburg, MD 21632 21. Signature of Funeral Service Licensee Michael 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) MP /Medical Due to (or as a consequence f): Examiner Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlal-transit that initiated even resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day 5 Other (specify) □Yes 2 □ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 Tyres Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 N 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Besidence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical

State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

Melitarano 31. Date filed (Month, Day, Year)

JAN 1 4 2010

29c. License number

29d. Date signed (Month, Day, Year)

and manner stated.

rastenn

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 829

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		•	1 - For State Registrar	State of M	larylan				lealth a D <i>eath</i>	ind Me		iene ()	10	0140	
			1. Decedent's Name (First, Middle, Las	st)						2	2. Date of Dea Month	th Day	Year	3. Time of Deatl	1
	Physici /Medio Examir	cal	Alfred 4a. Facility Name (If not institution, give	George street and number		yon	4b. City	, Town, or	Location of		January	7, 20	010 nty of Death	8:25 A	М
	Lxamii	ici	Caroline Nursing	Home, Inc			De	nton					Carol:	ine	
	Funeral		5. Social Security Number 6. S	ex 7. A		last birthday)		er 1 Year	If Under 2	24 Hrs. 8	B. Date of Birth (Month, Day			place (State or Fore	ign .
п	Director		166-68-3215	ДM 2□F	88	Yrs.	171011111	Jays	110010		anuary 2			ngland	
	pun 🛊		Usuet Residence of Decedent 10a. State 10b. County		10c. Cit	y. Town or Lo	cation							10d. Inside City Lim	nits
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	28e-1	ect	Maryland Carol 10e. Street and Number	THE		Dei		ip Code				I0g. Citizen o	of What Cou	ntry?	_
	with	Funeral Director	24911 Woods Driv					1629						of Americ	· a
	heath	era	11. Marital Status	12. Was Deceden	Ever in U.	.S. 13.			ispanic Orig	gin? (Spec	ify Yes or No- ican, etc.)	14. R	lace · Amer	can Indian,	
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Baltimore,	Dermit. Page Department of Importent: If any injury or ance.		 4 □Donation 5 □ Other (Specifical Service Lice) 21. Signature of Funeral Service Lice 	·	Ca	apito1			y ss of Facility	1/7/2		Dover	•		
Ba	permit. I Departm Importer any inju		Kou a blas	nove						1100	re Fune			.A. Land 2162	0
	75		23a. Pert1. Enter the disease, or com	plications that cause	d the deat	h. Do not en	ter the mo	ode of dyin	ig, such as	cardiac or	respiratory ar	rest,	mar y.	Approximate Interval Between	
	Dhusisian		shock, or heart failule. List only Immediate Cause (Final	one cause on each	line.	100	4xt	-24	~ / i	7	10	~		Onset and Death	
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	Examiner					,,.			1						
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Box	ath cer attendin for use	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom	2 🗌 Feta	t death 3		pregnancy	/				Date of deli Month	/ery Day Year	
0.	the a	ysic	1 Yes 2 No	4□ Pregnant : 9□ Unknown	at time of d	leath 5L	Other (specпу)							
Q	The law requires that the de ate has been signed by the a page 2 should be detached t		Part II. Other significant conditions of	ontributing to death	but not res	ulting in the u	inderlying	cause giv	en in Part I.		23e. Did to	bacco use c	ontribute to	the cause of death'	?
Records,	signed I	d by	Diahot	795 F	101	17	10				1 D Y	es 2 🗆 No	3 200	obably 4 □Unkno	own
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Vital			25. Was case referred to medical						OC Disco	of Death		2/Z No	1 🗌 Yes	2 No	
₹		o Be	examiner?	Hospital: 1 🗆 Innat	iont 2	ER/Outpatie	nt 3 🗆 [Oth	er /	rsing Hom	(Check only o	ence 6 🗆	Other (Sner	(h)	
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O	ding Phi th. : After thi s funeral	tion	1 Natural 5 Pending 2 Accident Investigatio		ay Year)	tnjury	м		K? Yes 2 ∐l	No					
Division	Attending or death. •ctor: After by the fune	ifice	3 Suicide 6 Could not be determined	288. Place of II	njury - At h	ome, farm, st	reet, facto	ory, office		2	8f. Location (S City or Tox		imber or Ru	ral Route Number,	
Ö	s afte	Certification:	1 Tiomicide	bullouing, 4	stc. (Specii	<i>(Y)</i>					ony 6. 7 on	, 0.0.07			
	To the Hospitel or Attenwithin 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier (Check only 2 Medicel Example 1	ysician: To the bes	t of my kno	owledge, dea	th occurre	d at the til	me, date an	nd place, a	nd due to the	cause(s) and	manner as	stated.	
	the H iin 24 the F iplete	Medical	one)	and manners		2007 4714207 11									
.	To To	2	29b. Signature and title of certifier	10		12	12	9c. Licens	e number	- /		29d. Date sig	gnea (Montr	, Day, Tear)	
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			30. Name and address of person who	completed cause of	death (Iter	m 23a) (Type	Print)	ank	of	- <	TD	0:1	211	MX)	
2.5		210	31. Date filed (Month, Day, Year)	3 Regis	trar's Sign	амте 4	1 K	411			· 40		ب رسو	100	
	St. Regist	ate	1AN - 7 20	10 Dages	a d	0. 190	6.54 m								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Helen Marie Metzler 4, 2010 Janury 9:05 p 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery Hospice-Casey House Rockville Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 □ M 2 🗗 F 040-14-2594 93 March 14, 1916 Pennsylvania Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits 1 ☐ Yes 2 TXNo Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12411 Atherton Drive 20906 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 21x No If Yes, Give Year or Dates Specify: Specify: 3 ₺ Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) US Department of Elementary/Secondary (0-12) College (1-4or 5+) Administration Clerk Health & Human Services 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frank Wilgot Antonia Sosanish 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Darryl Metzler/Son 12411 Atherton Drive, Silver Spring, MD 20906 Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐xBurial 2 ☐ Cremation 3 ☐ Removal from State Norbeck Memorial Park 4 Donation 5 ☐ Other (Specify) Olney, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final End-Stage Heart Disease disease or condition resulting in death) Due to (or as a consequence of): Acute Renal Insufficiency Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a our sequence of) resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 K No Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tyes 2 No 3 Probably 4 Unknown

Physician /Medical Examiner

t: If item 27

permit. Page Department o Important: If any injury or once.

Pages 1 f

Physician

Examiner

Funeral

Director

1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene.

tem 27 is marked other than "natural", or items 23a or 28a-f show wher traumatic event, It with Medical Evanting must be notified at

altimore, Maryland 21215-0036

/Medical

Director

Funeral

Completed by

Be

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Examiner

Physician/Medical

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and burial-tra the as nse for the detached cate has been signed , page 2 should be det certificate funeral director, this After

Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Hospital or Attending hours after death uneral Director: filled in by the within 24 hours a completely 2 20

			1 ☐ Yes 2 [□ No 3 □ Probably 4 ₺ Unknov		
			24a. Was an autopsy performed? 1 □Yes 25 □No	24b. Were autopsy findings availab prior to completion of cause o death? 1 □Yes 2 □No		
25. Was case referred to medical		26. Place of Dea	th (Check only one)			
examiner? 1 Yes 24∡No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	3 ☐ DOA Other: 4 ☐ Nursing H	lome 5 ☐ Residence 6	MOther (Specify) Hospice		
27. Manner of Death 1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation		28c. Injury at Work? M 1 □ Yes 2 □ No	28d. Describe how injury	occurred		
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street building, etc. (Specify)	28f. Location (Street and City or Town, State)	d Number or Rural Route Number,			
29a. Certifier 1 ☐ Certifying Ph (Check only one) 2 ☐ Medical Exam	ysician: To the best of my knowledge, death o niner: On the basis of examination and/or inves and manner stated.	ccurred at the time, date and place stigation, in my opinion, death occu	e, and due to the cause(s) urred at the time, date and	and manner as stated. place, and due to the cause(s)		
29b. Signature and title of certifier	0	29c. License number	29d. Date	e signed (Month, Day, Year)		
J. Koucet	chou, mo	263748		January 5, 2010		

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1355 Piccard Drive, Rockville, MD 20850 Jocelyne Kouatchou,

31. Date filed (Month, Day, Year)

JAN 06



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** IRENE MONTI MILANO 3 JAN 2010 3:52 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** NATIONAL NAVAL MEDICAL CENTER 8. Date of Birth (Month, Day, Year) 1. Trch 7, 1931 BETHESDA MONTGOMERY 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🖾 F Months Days Hours 145-28-8749 78 Director Jersey City, NJ Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Exar area? ust be notified at Director 1X Yes 2 No Maryland Prince George's Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 1 ö 4009 Clagett Road 20782 items 23a USA death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian filed within 72 hours after 1 ☐Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 2 🛛 No ō, 1 ☐ Yes 2 🛣 No Specify ð Specify: White 3 Widowed 4 Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry is 1 and 2 should be filed within 72 of Health and Mental Hygiene. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Education School Teacher 4+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Monti Irene Bancora ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trai once. Vito R. Milano / Husband 4009 Clagett Road, Hyattsville, MD 20782 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Metropolitan Crematory 1/10/2010 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Kon Gasch's Funeral Home, P.A. Hyattsville, MD 20781 stance 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** SEPSIS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last and burial-tra Due to (or as a consequence of): physician Physician/Medical the as IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ▼No Month Day Year 5 Other (specify) the detached 9 Unknown 9 Unknown Š signed I be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 2 🗌 No 1 ☐ Yes 2 🔀 No director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ∐ Yes 2 💢 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this filled in by the funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

P.O. Box 68760, Division of Vital Records, or Attending within 24 hours after deat To the Funeral Director; Hospital

Baltimore, Maryland 21215-0036

completely State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GREGORY S. FUHRER LT MC USN

and manner stated.

(Month, Day,

Registrar

29a. Certifier

(Check only one)

29b. Signature and title of certifier

1 🔁 Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

0101245334 (VA)

29d. Date signed (Month, Day, Year)

CENTER

Vanne

NATIONAL NAVAL MEDICAL

BETHESDA MD 20889-5600

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Agnes LaVerne Mercer <u>5:14</u> a^M Januarv Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 7409 Kipling Parkway District Heights Prince Georges Social Security Number . Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 . M 2 F Months Hours Mary Land 216-64-3906 Director 56 Usual Residence of Decedent and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f shor raumatic event, the Medical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Bant: If item 27 is marked other than "natural", or items 23a or 28a-f sho tant: If item 27 is marked other than "natural", or items 23a or 28a-f sho uny or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 □ No Maryland Prince Georges District Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7409 Kipling Parkway 20747 United States Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc þ 1 Never Married 2 K Married ☐ Yes 2 😿 No Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 K No Specify: If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ David Ray Anderson Civilla Agnes Scriber 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 7409 Kipling Parkway District Heights, Md. 20747 Clifton Mercer / Spouse Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place, Lincoln Memorial 1 X Burial 2 Cremation 3 Removal from State 1/11/2010 Suitland, Md. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lice 22. Name and Address of Facility 23a. Part 1. Enter the disease Pope / Forestville, Md. Alexander S. 5538 Mariboro 20747 Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final Physician Hypertension disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner embo Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examiner Cause (Disease or iinjury or Attending Physician: The law requires that the death certificate be executed the burial-transi (doe that initiated events resulting in death) Last and Due to (or as a consequence of attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Dav Year Pregnant at time of death 5 Other (specify) ☐ Pregnant :
☐ Unknown 1 | Yes 2 | 9 | Unknown this certificate has been signed by the arral director, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 🛣 No 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) B examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital: 1 XYes 2 ☐ No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 1 🛭 Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 24 hours after deatle Funeral Director. filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined Hospital Medical Excertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier completed (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one MC1744 29d. Date signed (Month, Day, Year)

State

Registrar

Marlboro Pike-Upper Marlboro

e and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2010 01408 Preston Morehouse State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Physician/ 1. Decedent's Name (First, Middle Last) 2. Date of Death Time of Death Month Day January 17, 2010 Medical Examiner 0445 hrs Preston Hylan Morehouse 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death 27257 Ocean Gateway Wicomico 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 9. Birthplace (State or **Funeral** 8. Date of Birth (MM/DD/YYYY) Director Months Davs Hours 230-57-9674 19 Oct. 12, 1990 $1XX_M$ CountryVirginia 2 F Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show notified at once, Florida Brevard Melbourne 1 Yes 2 XXNo permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. Director 10e. Street and Number 10f, Zip Code 10g, Citizen of What Country? 3507 Cappio Drive 32940 USA Funeral 11. Marital Status 12 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces 1XX Never Married 2 Married White etc. Yes 3 Widowed 4 Divorced If Yes, Give Year Yes 2 X X No specify: Specify: White 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 11 Clerk - Parts Dept. Automobile 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Danny Preston Morehouse Cynthia Richey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cynthia Martinez- Mother 3507 Cappio Drive Melbourne, Florida 32940 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 1 XX Burial 2 Cremation 3 Removal from State crematory or other place) Oak Hill Cemetery 1/23/2010 Fredericksburg, VA 4 Donation 5 Other Specify: 22. Name and Address of Facility 21. Signature of Funeral Service License 4801 Jefferson Davis HW 47/Covenant Funeral Service Fredericksburg, VA 2240 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Medical Doath a Shotgun Wound of Head Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Due to (or as a consequence of). Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical ending physician a use as the burial -UNPENDED AMENDED Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the the attending 3 Ectopic pregnancy Fetal death Month Day Year past 12 months? Pregnant at time of death 5 detached for 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 No 1 🗸 Yes Be

After this certificate has been To the Hospital or Attending Physician; within 24 hours after death. Division of Vital To the Funeral Director: completely filled in by the

Certification:

Was case referred to medical	al	26.Place of Death (Check only one)								
examiner? 1 ✓ Yes 2 No	Hos	pital: 1 Inpatient 2	ER/Outpatient 3	DOA	Other Nursi	ng Home 5 Residenc	e 6 🗸 Other: Scene			
27. Manner of Death		28a. Date of Injury	28b. Time of Injury	28c. Inju	ry at Work?	28d. Describe how injury	occurred			
1 Natural 5 Pen	dina	FOUND: Day, Year)	FOUND:	1 ,	Yes 2 No	Subject shot				
	stigation	Jan 17, 2010	0430 hrs							
3 Suicide 6 Cou	id not be	28e. Place of Injury - At ho	ome, farm, street, factor	y, office b	uilding, etc.	28f. Location (Street and	Number or Rural Rou	ite Number, City		
4 Homicide dete	ermined	(Specify) Single Fam	nily			or Town, State) 27257 Ocean Gateway	, Hebron, MD			
29a. Certifier 1 Certifying P	hysician:	To the best of my knowledge	ne, death occurred at th	e time. da	ate and place, and	due to the cause(s) and r	nanner as stated.			

2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifie

29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. January 18, 2010

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Ling Li, MD

and manner stated,

31. Date filed (Month Day, Year Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryl - State Amend Item 10c, 19b	land / Depa per inf <i>Cer</i>	rtment of Heal 1899, 01/27 tificate of Dea	/2010AN	ntal Hygi	ene g. No. O O I i	2 2 1 2 2
			1. Decedent's Name (First, Middle, Last)				. Date of Death	201	3. Fime of Beath
	Physicia		Donald Ross Murphy				Month January	5 2010	04:30 PM
1	/Medic Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Local			4c. County of De	
-	,	•	Union Hospital of Cecil Coun	ty	E1kton			Ceci1	
	Funeral			yrs. last birthday)		urs Min.	Date of Birth (Month, Day,	Year) (irthplace <i>(State or Foreign</i> Coun Charlestown
	Director		218-28-4332	6 Yrs.			June 13	,1933 Ma	ryland
	and ow	ŀ	Usual Residence of Decedent 10a. State 10b. County 10c.	c. City, Town or Loc	cation				10d. Inside City Limits
	Mary Find a	ţ	Maryland Cecil	North Ea	Elkton				1 □Yes 2 No
	r 28a	Director	10e. Street and Number	NOI CH La.	10f. Zip Code		10	g. Citizen of What (Country?
	th with		704 East Old Philadelphia Roa	.d	21901			nited Sta	tes
	ems ems	Funeral	11. Marital Status 12. Was Decedent Ever i Armed Forces?	in U.S. 13. V	Vas Decedent of Hispan Yes, specify Cuban, Me	ic Origin? (Spec exican, Puerto Ri	ify Yes or No- can, etc.)	14. Race - An Black, Wh	nerican Indian, ite, etc.
36	or it	by Fi	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	1		ecify:		Specify:	White
21215-0036	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show dical Examinar must be rediffed at	pe	3 ☐ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education	16a Deced	lent's Usual Occupation		- 11	16b. Kind of Busines	s/Industry
5	in 72 n "na nodic	Completed	(Specify only highest grade completed)	I (Give I	kind of work done during OO NOT use retired)	most of working			,
212	y with giene rr tha	E O	Elementary/Secondary (0-12) College (1-4or 5+)	Chie	f Custodian	<u> </u>		Public S	chools
Da.	e filed al Hy I othe vent,	Be C	17. Father's Name (First, Middle, Last)		18. 1	Mother's Name (First, Middle, N	faiden Surname)	
ylaı	ould b Ment arked aric e	2	Walter E. Murphy			Clara P			21021
Maryland	2 sho		19a. Informant's Name/Relationship (Type. Print)		g Address (Street and N				ast, Maryland
e, 1	1 and 2 Health em 27 i		Shirley Jane Murphy / Spouse 20a. Method of Disposition			Da	te 2	20c. Location - City	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		NEX Burial 2 Li Cremation 3 Li Removal from State		sition (Name of natory or other place)	Janua	ry 9,	•	
Ē	nit. Pa artme ortani Injury		4 □Donation 5 □ Other (Specify) C 21. Signature of Funeral Service Licensee		wn Cemetery . Name and Address of I				n, Maryland
Ва	Depar Impor any Ir once.		Valley L						aryland21901
п			23a. Part 1. Enter the disease, or complications that caused the caused shock, or heart failure. List only one cause on each line.	death. Do not ente	er the mode of dying, su	ch as cardiac or	respiratory arre	est,	Approximate Interval Between Onset and Death
and .	Physician		Immediate Cause (Final disease or condition a	DIAL I	NEALCTION	7			MINUTES
1	/Medical Examiner		resulting in death) Due to (or as a con						VC
		-			eky disei	ASE			YEARS
	uted d ansit	min	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		TIVE PUL	MANARY	DISEA	SE	YEARS
o,	exec an an rial-tr	Еха	resulting in death) Last Due to (or as a con	nsequence of):					
8760,	ficate be executed physician and s the burial-transit	dical Examiner	d HYPERT	CO15ND.					YEARS
	leath certific attending p	/Me	IF FEMALE: 23c. If yes, outcome of pr	regnancy				23d. Date of	delivery
Вох	death certif e attending d for use as	Physician/Me	in the past 12 months?	Fetal death 3	Ectopic pregnancy Other (specify)			Month	Day Year
P.O.	0 0 0	nysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown						
	w requires that s been signed k should be deta		Part II. Other significant conditions contributing to death but not	ot resulting in the ur	nderlying cause given in	Part I.	23e. Did tob	pacco use contribute	to the cause of death?
ğ	equire en siç oufd b	ed t	HYPERLIPIDEMIA				1 TYe	s 2 No 3	Probably 4 Unknown
ecc	(C) # (C)	Completed by					24a. Was ai	y prior	autopsy findings available o completion of cause of
=		Con					perform 1 □ Yes 2	ned? death	
Division of Vital Records,	nysician: The nis certificate director, pag	Be	25. Was case referred to medical examiner?		26.	Place of Death	(Check only on	e)	
of	dir ys	2	1 ☐ Yes 2 ☐ No Prospital: 1 ☐ Impatient 27. Mann Death 28a. Date of Injury	2 ER/Outpatien	IL 3 DOA 4			ence 6 Other (S	pecify)
o	ling After funer	tion	1		f 28c. Injury at Work? M 1 □ Yes		sa. Desemberne	Windary Coodings	
isi.	Attending ir death. ector: Afte by the fune	fica	3 Suicide 6 Could not be 28e. Place of Injury	At home, farm, stre	eet, factory, office	2			Rural Route Number,
ă	al or s after al Dire	Certification: To	4 Homicide determined building, etc. '(S _i	specify)			City or Towr	i, State)	
	To the Hospital or Attenc within 24 hours after death To the Funeral Director: completely filled in by the	Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my 2 Medical Examiner: On the basis of exa and manner stated.	amination and/or in	h occurred at the time, d vestigation, in my opinio	late and place, a on, death occurre	nd due to the c d at the time, d	ause(s) and manne ate and place, and o	as stated. Jue to the cause(s)
	To the within 2 To the comple	Mec	29b. Signature and title of certifier		29c. License nur	mber	2	9d. Date signed (Mo	onth, Day, Year)
	P ≤ P 0		1 4 M.D.		DOO H	1771		JANUAR	Y 6, 2010
	10		30. Name and address of person who completed cause of death	(Item 23a) (Type,	Print)	.			
	10		DAWW GAN-EL 304-306 N	lorth Str	reet Suite?	-3 Erk	M NOT	WEY LAND	31921
	Sta Regist		31. Date filed (Month, Day, Year) JAN 0 2010 Linear B.	Signature	/				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Year Physician P^{M} ARTHUR L. MCFADDEN 2010 7:20 JANUARY 02 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 611 CHAPEL HEIGHTS DRIVE HAVRE DE GRACE HARFORD 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M 2 □ F 87 Yrs SEPT 23, 248-18-5627 Director 1922 SOUTH CAROLINA Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show traumatic event, the Medical Examiner must be notified at Director MARYLAND HARFORD 1√2 Yes 2 No HAVRE DE GRACE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a or 611 CHAPEL HEIGHTS DRIVE 21078 UNITED STATES Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: 1940–45 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 **AFRICAN** 1 ☐Yes 2 No Specify. Specify: þ 3 X Widowed 4 □ Divorced "natural" **AMERICAN** Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) ORTHODONTIST DENTISTRY 12 Pages 1 and 2 should be filed v nent of Health and Mental Hygie int: If item 27 is marked other ! 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ARTHUR S. MCFADDEN HARRIET BRANCH ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 3 Department of Health Important: If item 27 any injury or other tr. once. THEON WHITE / DAUGHTER 611 CHAPEL HEIGHTS DRIVE, HAVRE DE GRACE, MD 21078 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GARRISON FOREST VET 01/12/10 OWINGS MILLS, MD 22. Name and Address of Facility
LISA SCOTT FUNERAL HOME, P.A.
552 LEWIS STREET, HAVRE DE GRACE, MD 21078 21. Signature of Funeral Service Licensee Kott- Comman 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final lyars **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to has a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Fctopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) ☐Yes 2☐No the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 4 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate death? 1 ☐ Yes 2 ☑ No 1 □Yes 2 🗹 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 1 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manne of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Funeral Director: 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only and manner stated. within 2 29c. License number
D0065827 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

5+IVA

10

State Registrar 31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

, 500 upper Chesapiake Dr. Bel Gir MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Physician/ 1:40 P M Hans Joachim Muller January 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Manor Care Potomac Potomac Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 472-24-9313 96 Germany Director Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10b. County 10c. City. Town or Location Ħ 10a. State Director be notified 1 Yes 2 XNo Maryland Montgomery Chevy Chase 10g. Citizen of What Country? è 10e. Street and Numbe 10f. Zip Code 23a Funeral must 4701 Willard Avenue Apt 1208 20815 United States 27 is marked other than "natural", or items traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) within 72 hours after death 12. Was Decedent Ever in U.S. 1. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. 1 XYes 2 No
If Yes, Give
Year or Dates. 1944–46 Completed by 1 Never Married 2 XMarried Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) US Census Bureau Statistician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental Health and Mental Health and Mental Health and Marked of ည Albert Muller Else Baer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Ottilie Muller/wife 4701 Willard Avenue Apt 1208 Chevy Chase, MD 20815 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of I Important: If it any injury or o' once. 듁 1 Burial 2 X Cremation 3 Removal from State Final Journey Crematory 1/6/2010 4 ☐ Donation 5 ☐ Other (Specify) Woodbine, Maryland Going Home Cremation Service P.O. Box 784 M00957 Beverly L. Heckrotte, P.A. Clarksville, M 21. Signa Pre of Funeral Service Licensee Clarksville, MD 21029 23a. Part V Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Ph_sician/ astati ance whenour Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, it day, leading to immediate cause. Enter Underlying Due to (or as a consequence of: sician and burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): ŵ attending physician for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy☐ Pregnant at time of death 5 ☐ Other (specify) ____ in the past 12 months? 4 Pregnant at time of death Yes 2 No 1 ☐ Yes ∠ ☐ 9 ☐ Unknown tor: After this certificate has been signed by the the funeral director, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed failur 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Aursing Home 5 Residence 6 Other (Specify) è 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 24 hours after death. Funeral Director: Al 1 🗌 Yes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. сопретер Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year, D0054566 114/2010. 1501 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suridha Bhogavilly 9 for Changia Annu + 1-17 Silverspring MD20902

Registrar
DHMH 17 Rev 7/2009

State

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Vear Month **Physician** Mary Ione Neal 2010 1:05p. January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 200 Pennsylvania Avenue Carroll Westminster If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days 1 M 2 X 64 072-36-0209 Director Jan 20 1945 NY Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 28a-f show other traumatic event, the Medical Examiner nast be resided at 1√Yes 2 No Director Carroll MD Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the "Modral Examination to once. 21157 200 Pennsylvania Avenue USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 □ No \$ Specify. white 3 ☐ Widowed 4 ☑ Divorced Year or Dates: Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) marketing office manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary VanAlstyne Fred A. Ladd ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Victor, daughter 3705 Whitehall Road, Hampstead, Md. 21074 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a, Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Carroll Cremation 1/4/2010 Hampstead, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility M00741 Eline Funeral Home Demmer <u>934 S. Main St., Hampstead, Md.</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final INFMICTION **Physician** MYOCALSIA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner DIAB { 1 23 MELLITUS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregn 3 Ectopic pregnancy in the past 12 mor 1 ☐ Yes 2 ☑ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 I Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Be Completed by 1 ☐ Yes 2 ☐ No 3 robably 4 🗍 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Yes 2 N 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Watural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 51715 2010 WJL 30. Name and address of persen who completed cause of death (Item 23a) (Type, Print) 410 235 3h7IMONE KOHIT GULATI, 3730 FAUS 21211 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death January Physician/ 03 3 9:00a M 2010 James William Neely Medical 4a, Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring Montgomery 704 Rosemere Avenue | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | April 29 6. Sex 1 💆 M 2 □ F 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** washington. Months 1943 66 Director 217-42-0098 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Examiner must be notified at Director 1 Yes 2 No Silver Spring Maruland Montaomeru 10f. Zip Code 10g. Citizen of What Country? 5 10e Street and Number items 23a Funeral 20904 U.S.A. 704 Rosemere Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No 9 þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White "natural", Completed 3 Widowed 4 X Divorced the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business Industry (Specify only highest grade completed) d 2 should be filed within 72 alth and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Commercial Electrician 10 other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Barbara Ellen Boteler James Robert Neely permit. Page 1 and 2 st.
Department of Health an.
Important: If item 27 is m.
any injury or other: 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 704 Rosemere Avenue. Silver Spring, Maryland 20904 William Beverly Neely - Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Lincoln Crematory 01/11/2010 | Brentwood, Maryland 4 Denation 5 Other (Specify) Signati 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. e of Fun 💤 I Serviga Licen e 11800 New Hampshire Ave., Silver Spring. MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Atherosclerotic Cardiovascular Disease Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Qualita for as a consequence of attending physician and for use as the burial-transit Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Year Month Day 4 Pregnant Pregnant at time of death 2 No the 9 Unknown nas been signed by 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 X No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an this certificate has autopsy page performed? Yes 2 X No ☐ Yes 2 ☐ No funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 은 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending s after death.
I Director: Af 1 ☐ Yes 2 ☐ No Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide completed filled in by determined 24 hours a Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check To the within 2 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MO OJ Duo po [1. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

M.D.

Registrar's Signat

NUM

Tahmina K. Ahmed,

JAN 06

31. Date filed (Month, Day,

831 University Blvd., East, #27, Silver Spring, MD 20903

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 9:10 PM January 2010 Patricia Anne Norris /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 41490 Garrett Court Leonardtown St. Mary's If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 13t F 84 Yrs. 578-28-2531 1925 District of Columbia Director April 4, Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural" ---- any injury or other traumatic events. 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 ☑ Yes 2 ☐ No Director Maryland St. Mary's Leonardtown 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20650 41490 Garrett Court USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ∐Yes 2 ∏ No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 1 ☐Yes 2K No Specify. Specify: White δ 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Fuel Oil Distributor Elementary/Secondary (0-12) College (1-4or 5+) Accounts Manager 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elizabeth Johns Babcock Christopher Columbus Mertz ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22194 Nomoni Street Leonardtown, MD 20650 Christopher Norris / Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition January 16, 1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State Leonardtown, Maryland St. Aloysius Cemetery 4 Donation 5 Other (Specify) 2010 Signadure of Funeral Service Lice 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.O. Box 270 Leonardtown, MD 20 Leonardtown, MD 20650 lardiner 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician RS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infine date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine the Hospital or Attending PhysIclan: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🔼 No 4 Pregnant at time of death 5 Other (specify) s been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has tri-irector, page 2 sl autopsy performe 1 ☐ Yes director, 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this After th funeral 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 □Yes 2 □ No hours after death. 2 Accident I Director: 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours after

To the Funeral Direcompletely filled in by 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signatu e and title of certifier

(10) profile

William D. Boyd, II, M.D. 25365 Pt.

Date filed (Month, Day, Year) 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2010

25365 Pt. Lookout Road

Leonardtown, MD 20650

31. Date filed (Month, Day, Year) JAN 13

A. Jane

Registrar

	-	For State	Plea	-	-		nd / Dep		nt of H	lealth	and N	II Copies Iental Hy	giene	9	le.	0	11.15
Physicia /Medic		- State Registrar 1. Decedent's Nam Barbara	ne (First, Middle a Jane N		L		CE	rtilica	te or	Deau	1	2. Date of De Month Januar		<u> </u>	Year		of Death
Examin		4a. Facility Name (If not institutio		eet and nun	nber)		4b. City, Town, or Location of Death Frederick					4c. County of Death Frederick				
Funeral Director		5. Social Security N 217-28-59		6. Sex	/ 2 X F	7. Age (<i>ln yr</i> :	s. last birthday Yrs.		If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birt (Month, Day June 24,					rth year) 1932 9. Birthplace (State or Foreign Country) Mary Land			
Maryland f show	tor	Usual Residence o 10a. State Maryland	10b. County	rederi	.ck	10c. C	City, Town or L	n or Location Frederick						10d. Inside			e City Limits
th with the Marylan 23a or 28a-f show	al Director	10e. Street and Nu 4894 Black		Lane			10f. Zip Code 21703						10g. Citizen of What Country? United States				
al", or items	by Funeral	11. Marital Status 1 Never Mari		ried	. Was Dece Armed For 1 Yes If Yes, Giv Year or Da	2 🔀 No e	U.S. 13	. Was Dece If Yes, sp 1 Yes		lispanic (an, Mexid Speci		pecify Yes or No Rican, etc.))-	14. Race - American Indian, Black, White, etc. Specify: White			,
filed within 72 ho Hygiene. other than "natur ent, the Medical	Completed	(Spe	15. Deceder cify only higher ondary (0-12)	nt's Educa est grade d	tion completed) College (1	-4or 5+)	(Giv	edent's Us re kind of w DO NOT tocker	ual Occup ork done use retire	oation during m d)	ost of work	ing	16b. Kind of Business/Industry Retail				
permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "in any Injury or other traumatic event; the Medione.	To Be Co	17. Father's Name	(First, Middle, Weddle	, Last)						18. Mo		e (First, Middle ce Fisher		n Surname	;)		
and 2 shore lealth and Pm 27 is mane trauma		19a. Informant's N	Grove /				741	6 Down	hill E		Freder.	ick, Mary	land				
t. Pages 1 tment of H tant: If ite		20a. Method of Dis 1 Burial 2 4 □ Donation	☐ Cremation 5 ☐ Other (moval from S	State H	Place of Dis cemetery, cr larmony Brethrer	hurch Cemet	of th		Janua 201		Му	rersvil			ners.
permit Depar Impor any In	21. Signature of Funeral Sovice Cicenses M01433 22. Name and Address of Facility Keeney & Basford P.A. Funeral Home 106 Fast Church Street, Frederick, M									Maryla	nd 21	701					
Physician /Medical Examiner pnujal-transit	al Examiner	23a. Part 1. Enter shock, or he Immediate Cause disease or condition resulting in death) Sequentially list or if any, leading to ir cause. Enter Und Cause (Disease othat initiated event resulting in death)	art failure. Lis (Final on) onditions, mmediate erlying r injury ts	b.	Due to (or as a consi	ARDI equence of): uti(equence of):	AL			Mic 1Ce		arrest,			Approxii Interval Onset a	Between and Death
The law requires that the death certificate be extended the law requires that the death certificate be extended the last been signed by the attending physician bage 2 should be detached for use as the buria	Physician/Medica	d. IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No							2 Estable Programmy						. Date of delivery Month Day Year		Year
w requires that the dibeen signed by the should be detached	þ	Part II. Other sign	ificant condit	ions contr	ributing to de	eath but not r	esulting in the	underlying	cause gi	ven in Pa	art I.		tobacco	use contr 2 🗌 No			of death?
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To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate I completely filled in by the funeral director, page	tion: To Be	25. Was case referexaminer? 1 ☐ Yes 2 6 27. Manner of Dea 1 ☑ Matural 2 ☐ Accident	ath 5 □ Pendi	Ho	28a. Date	<u> </u>	ER/Outpat	of	28c. Inju	her: 4 🗆	Nursing H	th (Check only lome 5 Res 28d. Describe	sidence			Daug fy)Resi	hter's dence
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the f.	Certification	3 Suicide 4 Homicide	6 Could deter	not be mined	28e. Place buildi	of Injury - At ng, etc. (Spe	t home, farm, ecify)	street, facto	ory, office			28f. Location City or To	(Street a	and Numb	er or Rui	al Route	Number,
ne Hospita n 24 hours ne Funera	Medical (29a. Certifier (Check only one)	1 Certify 2 Medica	ing Physi Il Examin	er: On the b	best of my leasis of exam ner stated.	ination and/or	investigati	on, in my	opinion,	death occu	e, and due to thurred at the time	e, date a	and place, a	anner as and due	stated. to the cau	ise(s)
To the within to the complete	M	29b. Signature an	A-Z	100	AZi	WO		2	9c. Licen	ise numb	i & 4	k mo	29d. [Date signed	Month —	Day, Yea	ar)
		30. Name and add	EGA Z	4 46	BT	hours.	tem 23a) (Typ	e, Print) 1504 [Dii	c F	releri	k ano.	21	702			
Sta Registr		31. Date filed (Mo	AN 22			tegistrar's Sig	gnaydre	arel.	2								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Day **Physician** 201 10 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Prince Georges Bowie Health Center Birthplace (State or Foreign Country) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 🖺 F Yrs. 01/11/1930 Virginia **Director** 79 230-34-2050 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 28a-f show r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 1X Yes 2 □ No Director MD Springdale Prince Georges 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 20774 USA 3527 Edwards Street 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ★ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No Specify. Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: Specify ò 3 ☑ Widowed 4 ☐ Divorced Black. Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Dept. of Agriculture Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Medical Technologist 4 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be nd 2 should be fill the and Mental H 27 is merked ot reaumetic ever Lonnie_Johnson ၉ Frank Broady 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 s ment of Health an ant: If item 27 is 1 Wayne Owens - Son <u> 219 Hobbitts Lane Westminster, MD 21158</u> 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date ō 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Ft. Lincoln Cemetery 1/09/2010 permit. Page Department i Important: If any Injury of office. Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ft. Lincoln Funeral Home, Inc. 21. Signature of Funeral Service Licensee 3401 Bladensburg Road Brentwood, MD 20722 mye Montaohery Approximate Interval Between Onset and Death 23a. art 1 Enter the usear or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a) onsequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed ending physician and use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical ned by the attending in detached for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d, Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No 3 Ectopic pregnancy Year Month Day 5 Other (specify) 9 Unknown Atter this certificate has been signed by funeral director, page 2 should be detacl 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 2 🗆 No 1 ☐ Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1∐ Yes 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie and address of person who completed cause of death (Item 23a) (Type, Print) 808 m 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of De Physician P^{M} January 2010 5:37 Joe Phipps /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll Westminster 1039 Arnold Rd. If Under 1 Year | If Under 24 Hrs. 6. Sex Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, **Funeral** Days Year) Min. 1 XM 2 □ F 10, Grassy Creek,NC 1935 Director 242-52-2547 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, it a Marical Evarings must be notified at 1 ∐ Yes 2 🔼 Ño Westminster MD Carroll Director 10g. Citizen of What Country? U.S.A. 10f. Zip Code 21157 10e. Street and Number 1039 Arnold Rd. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1954- Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status Black, White, etc. 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Maryland 21215-0036 1958 White 1 ∐Yes 2 🔀 No Specify: ≥ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7, th and Mental Hygiene. 7 is marked other than "ns College (1-4or 5+) Elementary/Secondary (0-12) Electrical Engineer Engineering 12 18. Mother's Name (First, Middle, Maiden Surname)
Madeline Cox 17. Father's Name (First, Middle, Last) Be Chester Phipps 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 st Department of Health and Important; If item 27 is n any Injury or other traun once. Arnold Rd., 1039 Westminster, Shirley Jean Phipps Wife altimore. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State Jan. 6, 2010 Grassy Creek, NC New River Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 12 Washington Rd., Westminster, MD 21157 Pritts Funeral Home & Chapel, P.A. ach 23a. Part1. Enter the deease, or complications that dused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final he **Physician** disease or condition resulting in death) /Medical as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Attending Physician; The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) attending physician for use as the buria Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 Other (specify) signed by the a Division of Vital Records, P.O. 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown icate has been sig , page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performe 1 ☐ Yes 2 No 25. Was case referred to medical director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After t 1 Natural 5 Pending To the Hospital or Attendii within 24 hours after death. To the Funeral Director; A ∆ completely filled in by the fu death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) ture and title of certifier 29b. Sign

State Registrar 30 Name

d address of person who completed

Year)

JAN 05

31. Date filed (Month, Day,

NJ

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se of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 = For State Registrar	State of Maryland	l / Depa		lealth and N	Mental Hygi	_	01418	
	Dhoraini		1. Decedent's Name (First, Middle, Last)					2. Date of Death		3. Time of Death	
	Physici /Medio		Clarence Por	ter				JAN.	$12^{\text{ay}}, 2010$	1837 M	
	Examin		4a. Facility Name (If not institution, give s Caroline Nursia			4b. City. Town, o	r Location of Death O N		4c. County of De Caro		
	Funeral Director		210 07 1404	7. Age (in yrs. ia MM 2□F 99	st birthday) Yrs.	if Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month Say, May 28,	^{9. B} Ma	rthplace (State or Foreign Country) ryland	
	Maryland -f show	tor	Usual Residence of Decedent 10a. State 10b. County MD Carolin	-	Town or Lo	cation nton				10d. Inside City Limits 1 🗹 Yes 2 🗌 No	
	h with the	Funeral Director	10e. Street and Number 520 Kerr Avenu	e		10f. Zip Code 21629			10g. Citizen of What Country? United States		
036	within 72 hours after death with the Maryland ene. ane. Than "hatural", or Items 23a or 28a-f show the Madical Examirer must be notified at	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	ì	Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2☐xNo	lispanic Origin? (Span, Mexican, Puerto	pecify Yes or No- p Rican, etc.)	14. Race - Am Black, Wh Specify: W	ite, etc.	
Maryland 21215-0036	77 75 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation a completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired er Oper	during most of world)	6b. Kind of Busines Feed Mil			
yland	d be ental ked o	To Be C	17. Father's Name (First, Middle, Last) Joshua Porter				Lizzie				
	s 1 and 2 should Health and Milem 27 is mark		Joyce F. Armes/	Daughter	115	Charlot	te Ave.	, Feder		MD 21632	
Baltimore,	Page ent o nt: If ry or		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)			sition (Name of natory or other plac Cemete			oc. Location - City o Federals		
Balt	permit. Departm Importa any inju	The care is the same of the sa							neral Hom urg, MD 2	e, P.A. 1632	
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	cations that caused the death. le cause on each line. Due to (or as a conseque	0				disease	Approximate Interval Between Onset and Death	
760,	te be executed ysician and ne burial-transit	ilcai Examiner	Feducation is a condition of any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque	,		-				
P.O. Box 68	The law requires that the death certificate to the has been signed by the attending physic bage 2 should be detached for use as the bage.	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregnand 1 Live birth 2 Fetal of 4 Pregnant at time of deal 9 Unknown	leath 3	Ectopic pregnancy Other (specify)	,		23d. Date of de Month	elivery Day Year	
	uires that signed t Id be deta	by	Part II. Other significant conditions con	tributing to death but not result	ing in the u	nderlying cause giv	en in Part I.	23e. Did toba		to the cause of death? Probably 4 Unknown	
Records,	The law requirate has been s page 2 should	Completed	CHF					24a. Was an autopsy perform	prior to	autopsy findings available completion of cause of	
Vita	10 101	0	25. Was case referred to medical				26. Place of Deat	1 ☐ Yes 2)		2 5 140	
>	Physician: this certific ral director, i	To B	examiner? 1 Yes 2 No	ospital: 1 ☐ Inpatient 2 ☐ E	R/Outpatien	t 3 DOA Oth	er: 4 Nursing He	ome 5 🗆 Residen	nce 6 Other (Sp	ecify)	
Division of	nding Pl ath. r: After ti e funera		27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	8b. Time of Injury	28c. Injur Wor M 1	y at k? Yes 2 □ No	28d. Describe how	v injury occurred		
Divis	tai or Atters after de al Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	e, farm, str	eet, factory, office		28f. Location (Stre City or Town,	eet and Number or F State)	Rural Route Number,	
	To the Hospital or Attending Physician; within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	edical	29a. Certifier 1 ☐ Certifying Phys (Check only one) 1 ☐ Medical Examin	ician: To the best of my knowler: On the basis of examination and manner stated.	edge, death n and/or inv	occurred at the tin vestigation, in my o	ne, date and place, pinion, death occur	and due to the cau red at the time, dat	use(s) and manner a le and place, and du	is stated. le to the cause(s)	
	Mith To t Com	W	29b. Signature and title of certifler	ARI 4	0	29c. Licens	o 475		d. Date signed (Mor	oth, Day, Year)	
			30. Name and address of person who co Mafik ZaKi,	mpleted cause of death (Item 2 M D 920 A	3a) (Type. Aavile			n, MD	21629		
	Sta Registr	-	31. Date filed (Month, Day, Year)	82. Registrar's Signatu	re Ason	el d					

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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ рм Toni Lynn Perrell January 2:06 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery Bethesda Suburban Hospital 9. Birthplace (State or Foreign 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🛛 F Days Min. washington, 0474871967 Director 42 228-06-6682 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Tes 2 No Kensington Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe Completed by Funeral 20895 U.S.A 4013 Burd Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Never Married 2 Married 2 X No 1 ☐ Yes If Yes, Give 1 ☐ Yes 2 X No Specify: 3 ☐ Widowed 4 ☐ Divorced White. Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) World Com Administrative Assistant Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Beverly Schreiber James Douglas Perrell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Teresa Ann Perrell - Sister 4013 Byrd Road, Kensington, Maryland 20895 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ☐ Burial 2 🛛 Cremation 3 ☐ Removal from State 01/08/2010 Brentwood, Maryland Lincoln Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service Licensee 11800 New Hampshire Ave., Silver Spring, MD 20904 0~~ complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, inly one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, shock, or heart failure. List Immediate Cause (Final oronavy Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner bacco 0 Sequentially list conditions Examine Due to (or as a consequence of, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 4 Pregnant at time of death 9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? 1 🗆 🔀 2 🗆 No Dav Month 1 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a Was an autopsy performed 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examine? 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 FR/Outpatient 3 IDOA မ 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate:

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. physician and s the burial-trans attending pl cate has been signed by the a page 2 should be detached After this certificate within 24 hours after deati To the Funeral Director.

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Vital Records,

Division

marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at

Important: If item 2 any injury or other

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

(Month, Day, Year) 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide ☐ Suiciae ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D. 8600 Old Georgetown Road, Bethesda, Maryland 20814 Matthew M. Leonard.

29d. Date signed (Month, Day, Year)

29b. Signature and title of certifie

31. Date filed (Month, Day, Year) JAN 06 Registrar's Signat

State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician/ 2010 9:20 A M January Reimherr Beulah Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Shady Grove Adventist Rockville 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Days Sept. 15, 1920 New York Hours 1 🗆 M 2 🗓 F 89 **Director** 096-16-6144 Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Director notified Rockville 1 ☐ Yes 2 ☐ No Md. Montgomery 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 5 ms 23a or must be r Completed by Funeral USA 20850 9701 -Veirs Drive "natural", or items dical Examiner mu Page 1 and 2 should be filed within 72 hours after death Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc 1 Never Married 2 Married 1 Yes If Yes, Give 2**X** No Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: White Specify: 3 X Widowed 4 ☐ Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) f Health and Mental Hygiene.
item 27 is marked other than
other traumatic event, the Me College (1-4 or 5+) Elementary/Seconday (0-12) Education School Teacher 4 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Isabel Knapp Floyd Knapp 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6913-Prince Georges Ave., Takoma Park, Md. Ms.Jovce Reimherr-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Page 1
Department of
Important: If it
any injury or o 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 1/5/2010 Metropolitan Crematory Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 222-Wisconsin Ave. . Signature of Funeral Service Lice Hysong Co. Washington, DC 20007 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Respiratory Failure disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Aspiration Pneumonia Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) physician and s the burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 X No Day Month Year Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has the irector, page 2 s autopsy perform 1 ☐ Yes 2 ☐ No ☐ Yes 2 X No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No Be (Division of Vital 26. Place of Death (Check only one) မ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After X Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation after death

Director: A

in by the f 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗌 only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of confine 29c, License number 29d. Date signed (Month, Day, Year) 66189 January 3, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Meeankhi Andrew- Shady Grove Hospital, Rockville, Md. 31. Date filed (Month, Day, Year) **34N 0 8 2010** 32. Registrar's Signatur

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 13,2010 **Physician** Month BURNICE C. REED January 8:46A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Upper Chesapeake Med. Center Bel Air Harford 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days **№** M 2 F Hours 404-26-3631 Director 83 1/1926 Kentucky Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28a-f sh Director 1 ☐ Yes 2 🔀 No MD Harford Abingdon 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2810 Meredith Court 21009 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: ₩₩II 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married þ 1 ☐ Yes 2 ☐ No Specify Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Cement Finisher Construction 4 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be A. G. Reed ပ Georgia Keel 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruby I. Bentley/Daughter 42 Amber Drive, Delta, PA 17314 Department of Heal important: if item 2 any injury or other once. timbre, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Zion Cemetery 1/18/2010 Bel Air, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Euneral Service Licery 22. Name and Address of Facility Harkins Funeral Home, Inc., Delta, PA 17314 23a. Part 1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Lest only one cause on each line. t and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an of Vital 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) H0067817 2010

State Registrar ousageare.

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death Day 15 1. Decedent's Name (First, Middle, Last) Year **Physician** 12:00p M **JANUARY** 2010 GEORGE ROGER RINGGOLD /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 110 West Cross St. Galena Kent Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Y Feb 20 **Funeral** Months Days Hours 219-14-3253 84 1925 Maryland Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits items 23a or 28a-f show ust be notified at 1 Yes 2 □ No. Director MD Kent Galena 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or important: If item 27 is marked other than "natural", or items 23a or any Injury or other traumatic event, Ite Macinal Examinate but once. 110 West Cross St. 21635 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. þ Specify: White 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Auto Mechanic Auto Garage 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Roland Ringgold Clara Bowers ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) E. Allen Mulford, Jr. (nephew) 208 Edjil Dr. Newark, DE. 19713 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Removal from State 4 Donation 5 Other (Specify) Kent Cremation 1/16/2010 Smyrna, DE. 22. Name and Address of Facility
Galena Funeral Home of Stephen L Schaech 21. Signature of Funeral Service M00510 118 West Cross St. Galena, MD. 21635 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, snock, or heart failure. List only one cause on each line. Immediate C use (Final disease or condition resulting in death) FNLARGING NECK **Physician** MO /Medical Due to a as a consequence of): Examiner avanoma robable Esqueribility list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month Year Day Pregnant at time of death 5 Other (specify) ☐Yes 2☐No been signed by the should be detached 9 Unknown 9 Linknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>გ</u> pendent 2 1 Tes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a, Was an certificate has birector, page 2 s autopsy 2 ours after death.

neral Director: After this certificat
v filled in by the funeral director, pc 1 ☐ Yes Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Acsidence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 24 hours a 29a, Certifier 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical within 24 hou To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

32. Registrar's Signature

to completed cause of death (Item 23a) (Type, Print)

salena

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day EDWIN GRAHAM RIGGS 1350 PM Jan Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HAGERSTOWN WASHINGTON COUNTY HOSPITAL WASHINGTON Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 218-30-2771 1 **X** M 2 □ F **76** Months Days Hours 1/957 P934" MARY Y'L'AND Director Usual Residence of Decedent shov 10a. State 10c. City, Town or Location 10d. Inside City Limits er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director WV BERKELEY FALLING WATERS 1 ☐ Yes 2 🕅 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3018 GRADE ROAD 25419 USA Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Xes 2 No
If Yes, Give Black White etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: WHITE Completed 3 ☑ Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) P LUMB ER COMMERCIAL is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ GEORGE W. RIGGS GUELDA GRAY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s if Health a item 27 i PO BOX 62, FALLING WATERS, WV 25419 LARRY CANNEDY/SON permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr Baltimore, 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State 1)(☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) VIRGINIA VETERANS CEM. AMELIA, VA 2010 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 22. Name and Address of Facility BROWN FUNERAL HOME, PO BOX 821, 327 W. KING ST., MARTINSBURG, WV 25402 Charles M. Brown 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner AGLE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical death certificate be Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) Dav 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown P.O. by signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Direce Division of Vital Records. 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No certificate has page 2 · hyperlipidenia To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificat

"moleted filled in by the funeral director, F 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2 1 Impatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of Certificate: 28d. Describe how injury occurred injury 1 - Natūral 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined ca Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) JA~ 13,2010

State Registrar 31. Date filed (Month, Day, Year) JAN 21 2010

auxmo

VASANT DATTAMO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signatur

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MILL ST

HAKERSTOWN MOZITHO

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			For State Registrar	State of Maryla		artment of ertificate of			jiene	10	01424	
	Physici		1. Decedent's Name (First, Middle, Last) Mildred	Rose				2. Date of Dea Month	th Day	Year 2010	3. Time of Death	
	/Medic Examir Funeral		4a. Fecility Name (If not institution, give s Lyenese Low 5. Social Security Number 6. Sex	yhile Ce	nlev urs. last birthday	S	or Location of De	Apring	N	onty of Death Ontg		
	Director			M 2/VE	80 Yrs.	Months Day	s Hours M	lin. (Month, Day May 31	1929	1929 Virginia		
	he Maryland 28a-f ehow outlied at	ector	10a. State 10b. County Maryland Montgom		City, Town or L	ilver Sp				10d. Inside City Limits 1 ☐ Yes 2 ☑ No		
	Mith With	Dir	10e. Street and Number 3227 Bel Pre Road			10f. Zip Code	0906			of What Count ed Stat	·	
36	be filed within 72 hours after deeth with the Maryland stal Hyglene. Id other than "natural", or items 23a or 28a-f ehow event, the Medical Exartiral must be notified at	by Funeral Director		12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	n U.S. 13.		Hispanic Origin? ban, Mexican, Pu	(Specify Yes or No- uerto Rican, etc.)	14. Ri	ace - America lack, White, e	an Indian,	
21215-0036	within 72 hou sne. Ihan "natura se Medical E	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation	edent's Usual Occ e kind of work don DO NOT use reti	e during most of	working	Non p	Business/Ind profit	dustry		
73	be filed ital Hygi id other event, I	To Be Co	8 17. Father's Name (First, Middle, Last) William Henry	Rose	Chef	18. Mother's t	Name (First, Middle, Morris	Maiden Suma	nizatio ame)	ac		
ary	2 should be and Mental is marked o	F	19a. Informant's Name/Relationship (Ty)		19b. Mai	ing Address (Stree		Rural Route Number		m, State, Zip	Code)	
Σ,	ss 1 and 2 of Health a ltem 27 is r other train		Njeri Mwalimu/nie		and the second second		a Dr Upp	per Marlbo	oro, Ma	iryland	3 20772	
lore	tges 1 and 2 should nt of Health and Mer til Item 27 is marke or other traumatic		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ R	emoval from State	cemetery, cre	osition (Name of ematory or other p	1			n - City or To		
Baltimore,	permit. Pages Opportment of H Important: if Ite eny injury or of		4 Donation 5 Other (Specify) 21. Signature of Funeral Service License	99	8	urney Cre 2. Name and Add 30ing Hor	ress of Facility	tion Servi	ce P.	O. Box	Maryland x 784	
			23a. Party. Enter the disease, or compli-	cations that caused the d						:ksvill	Le, MD 2102	
	Physician /Medical Examiner	Examiner	shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons	sequence of):	Myelo	na G	ncer			Interval Between Onset and Death	
68760,	rificate be executed ng physicien and as the burial-transit	lical	IF FEMALE:		sequence (ii).							
P.O. Box	The law requires that the death certific tie has been signed by the atlending p bage 2 should be detached for use as	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of preduction 1 Live birth 2 F 4 Pregnant at time of 9 Unknown	etal death 3	□Ectopic pregnan □ Other (specify)	су			Date of deliver Month	ry Day Year	
ords, P	w requires that been signed b should be deta	þ	Part II. Other significant conditions con	tributing to death but not	resulting in the	underlying cause g	iven in Part I.		bacco use co es 2 □ No		e cause of death?	
	n: The law ificate has bur, page 2 sh	e Completed						24a. Was a autops perfore 1 Tes	sy .	prior to con death?	psy findings available inpletion of cause of 2 No	
Ξ	rsicie s certi directo	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	ospital: 1 Inpatient 2	☐ ER/Outpatie	at 30 004 0	4	Death <i>Check only</i> on g Home 5 ☐ Reside	-			
ion of	Attending Physicien: r death. ector: After this certifica by the funeral director,		27. Manner of Death 1 Watural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day Year,	28b. Time	of 28c. Inj		28d. Describe ho			,	
Divis		Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, si	reet, factory, office	•	28f. Location (Si City or Town	treet and Nur n, State)	nber or Rural	Route Number,	
	To the Hospital or within 24 hours afte to the Funeral Dir completely filled in	ledicai	one) 2 Medical Examin	ician: To the best of my ler: On the basis of exam and manner stated.	nowledge, dea ination and/or in	nvestigation, in my	opinion, death of	ace, and due to the cocurred at the time, d	ause(s) and r ate and place	nanner as sta e, and due to	ated. the cause(s)	
)	To the within 1	Σ	29b. Signature and title of certifier	Mr	1.D.		6420			ned (Month, D	Day, Year)	
3			30. Name and address of person who co	n 3227	tem 23a) (Type Bel	Print) Ro	ad Sil	lner Spr	ing 1	MD 2	0906.	
	Sta Registr		31. Date filed (Month, Day, Year)	32 Registrar's Sig	nature 4	ukel		•	U			

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Amended Item 16a per F.D. 01/06/2010 Carroll County, wjl.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 5, 2010 Ye Month **Physician** М 1333 January Ralph Wiley Sloan /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Carroll Westminster Dove House If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 1√2 M 2 □ F Hours Director 91 July 12, 1918 Maryland 215-14-5951 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show the Medical Examiner must be notified at Director 1 XYes 2 No MDCarroll Westminster 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6 23a USA 300 St. Luke Cir. 21158 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 XYes 2 No 1943 If Yes, Give Year or Dates: 1946 1 ☐ Never Married 2 ☐ Married 21215-0036 jo, 1 ☐ Yes 2 🛣 No Specify ≥ Specify: 3 □ Widowed 4 □ Divorced White "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than " any injury or other traumatic event, It a I way once. Aberdeen Architect Engineer Elementary/Secondary (0-12) College (1-4or 5+) Proving Grounds Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Elonzo Sloan 2 Mary Wiley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2601 Old Taneytown Rd. Westminster, MD 21158 e of Disposition (Name of D Cornelia Gibson Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) Bethel Presby. Cem 1/9/10 Madonna, Maryland 22. Name and Address of Facility Pritts Funeral Home & Chapel, PA 21. Signature of Funeral Service Licenses 412 Washington Rd. Westminster, MD Approximate Interval Between Onset and Death 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (as a consequence of): **Physician** Preumenic wilco /Medical Examiner Advanced COPN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the death certificate be executed Due to (or as a consequence of): sician and burial-trans attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No cate has been signed by the page 2 should be detached Ö 9 I Inknown 9 Unknown σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ Chrome B.FILE CUR 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed Phuntompeun B& 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 MNo Vital completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? ie Hospital or Attending P n 24 hours after death. ie Funeral Director: After t 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide to Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the best of examination and or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) To the I within 2 To the I 29b. Signature and title of confifier 29c. License number 29d. Date signed (Month, Day, Year) MJL 1-4-2010 IOTIVA ted cause of death (Item 23a) (Type, Print) 30. Name and address of person shout here Suite 4201, Westmerer Bugdaschursh 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Eddie W. Singleton 3, 2010 2205 January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Shady Grove Adventist Hospital Rockville Montgomery Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 X M 2 □ 062-36-0704 Yrs. 61 05/13/1948 Director South Carolina Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "nature!" — any injury or other traumatic events. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 No Director Maryland Montgomery Germantown 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 13120 Wonderland Way Condo 102 20874 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 In No Specify: Specify: ģ black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 3+ Information Technology network engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ed D. Singleton Jr. Onetha Hayes ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type. Print) 6138 Andrew Thomas Dr., Apt. 222, Charlotte, NC 28269 Penny D. Singleton/daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 K Cremation 3 ☐ Removal from State Salisbury Crematory 1/8/2010 4 Donation 5 Dother (Specify) Salisbury, MD 22. Name and Address of Facility 21. Signe of Funeral Service License Stewart Funeral Home, 821 West Rd., Salis., MD2180 23a Part 1. Enter the disease, or complications that shock, or heart failure. List only one cause of Approximate Interval Between Onset and Death caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, a each line. Immediate Cause (Final **Physician** disease or condition resulting in death) Sepsis
Due to (or as a consequence of): /Medical **Examiner** 10 <u>end stage renal</u> disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-fransit completely filled in by the funeral director, page 2 should be detached for use as the burial-fransit coronary artery disease Due to (or as a consequence of): Box 68760 Physician/Medical anemia IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 🗆 Ectopic pregnancy Month Day Year 5 Other (specify) P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown hypertension, stroke 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an gout autopsy performe 1 □Yes 2 X No 1 □Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ KNo Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D59013 1/4/2010

13

State 31. Date filed (Month, Day, Yes

JAN 07 2010

Konstant Khludenev,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD 15825 Shady Grove Rd., Suite 140, Rockville, MD 20850

32. Pfgistrar's Signature for Aparts

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 1 0 Certificate of Death Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Ernestine F. Stein January 4, 2010 al 3:40 a M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Mon tgomery Holy Cross Hospital Silver Spring 5. Social Security Number If Under 24 Hrs. 8. Date of Birth If Under 1 Year Funeral 6. Sex 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign 1 🗆 M 2 🛣 F Days Feb. 20, Year 1917 Kentucky 579-05-9444 92 Director Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location should be filed within 72 hours after death with the Maryland Director 10d. Inside City Limits or 28a-f sl 1 Yes 2 No Maryland Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 5 10a, Citizen of What Country? ms 23a or must be r Funeral 3100 Verona Court 20906 USA ral", or items ? 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 2 **X**No 1 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: White "natural". 3 ₩ Widowed 4 □ Divorced Specify: Completed Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) id Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12 Computer Specialist Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . nOre,
.iit. Page 1 and 2 sho.
.ent of Health and Me.
'them 27 is marked o.
.r traumatic evr Mental F မ Jackson B. Farris Alberta Barton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Farthing/Personal Rep 451 Hungerford Drive, #750, Rockville, MD 20850 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 😾 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Jan. 2010 permit. Page Department of Important: If any injury or once. 11, George Washington Cem. Adelphi, Maryland 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Cardiopulmonary Arrest disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner End-Stage Renal Disease Sequentially list conditions. Examiner Due to for as a consequence of cause. Enter Underlying or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury been signed by the attending physician and should be detached for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 🛣 No Pregnant at time of death Month Day Year 4 Pregnant
9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 😾 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? Yes 2 No this certificate 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: 1 Tyes 2 🔀 No Certificate: To 1 x Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 1X Natural 5 Pending work nours after death.

neral Director: A

filled in by the fu 1 Yes 2 No ☐ Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Hospital Medical 29a. Certifier 🛚 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D63343 January 4, 2010

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

JAN 06

30. Name and address of pe son who completed cause of death (Item 23a) (Type, Print)
Irina Y. Ruban, MD 1500 Forest Glen Road, Silver Spring, MD 20910

Registrar's Signat

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Amend#23b. PerPhys. PGC1-8-2016 extificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month ປື້5**,** <u>201</u>0 George M. Spriggs Jr pM January 4:25 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Cherry Lane Nursing Prince George Laurel Center 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Nov 10 9. Birthplace (State or Foreign **Funeral** 1 🔀 M 2 🗆 F Months Days Hours Min. ar) 1936 Maryland Director 215-34-3765 73 Nov Usual Residence of Decedent shov 10a, State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director or 28a-f s notified Laurel Prince George Md 1 XYes 2 No 10e, Street and Number 10f. Zip Code 9 10g. Citizen of What Country? 27 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be Funeral 11420 Hermosa Drive 20708 USA permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give 7 4
Year or Date 7 4 If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 XMarried Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black Completed 3 Divorced 4 Divorced 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Supervisor Holy Cross Hospital 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ George M. Spriggs Sr. Mary F. Coleman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11420 Hermosa Drive Laurel Maryland 20708 Nadine M. Spriggs(Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Arlington Nat'lCemJan 20,10 |Arlington Virginia 4 Donation 5 Other (Specify) of Final Service Licenses 21. Signatu 22. Name and Address of Facility 20011 Tyrone J. Young 719 Kennedy St. 18 NW WashDC r the disease, or co caused the deaty. Fo not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1 neart failure. List only one cause shoc each line Interval Between Immediate Pause (Final Onset and Death Physician/ GASTRIC CANCER etastatic Monks disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of). attending physician and I for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Pregnant at time of death Other (specify) Month Day Year signed by the all Id be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ HY PERTENSION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 X No page 2 1 Yes 2 No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 X No 2 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 🔀 Natural 5 Pending work? 1 🗌 Yes 2 🗌 No To the Hospital or Attendir within 24 hours after death. To the Funeral Director: At completed filled in by the fu 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifie 1 🕰 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 only one) Ashsas 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

-DI-St

Date filed (Month, Day, Year JAN 0 8 2010 filed (Month, Day, Year) 53411

Bowie

14300 Gallow Force

MD

0715

210

2010

Jan.

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20715

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Velma L. Sams January 8, Day 2010 Year 6:15 A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Charlotte Hall Veterans Home Charlotte Hall Mary's 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 8. Date of Birth 9. Birthplace (State or Foreign If Under 24 Hrs. **Funeral** 1 M 2 7 F Days Hours Min. Months 03/211/1920 232-72-4517 89 West Virginia Director Usual Residence of Decedent or 28a-f show notified at show 10a. State 10c. City, Town or Location hours after death with the Maryland 10d. Inside City Limits Director Maryland | 1 Yes 2 X No Charlotte Hall St. Mary's ò 10f. Zip Code 10g. Citizen of What Country? Examiner must be Funeral 23a United States 20622 29449 Charlotte Hall Road items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. P þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Tes 2 No Specify: White 3X Widowed 4 ☐ Divorced Specify: "natural" Completed event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker At Home and Mental Hygie is marked other æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Allen H. Michael Effie Angeline permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janice Hamby/Daughter 38474 Laurel Ridge Dr., Mechanicsville, MD 20659 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
Maryland Veterans Cem 1 🗓 Burial 2 🗆 Cremation 3 🗆 Removal from State January 2010 Cheltenham, MD 4 ☐ ponation 5 ☐ Other (Specify) ure of Funeral Service Licenses Brinsfield-Echols F.H., P.A., 22. Name and Address of Facility MO0817 PO Box 128, Charlotte Hall, MD 20622 Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ARRHYTHMIA ARDIAC disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner HEART FAILURE CONGESTIVE Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events CHRONIC OBSTRUCTIVE PULMONARY DISEASE Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent preguant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 month ☐ Pregnant at time of death☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ RENAL FAILURE Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 Yes 2 No 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of Certificate: 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check 3 □ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of contifier 29d, Date signed (Month, Day, Year) are MD D0067788 8.2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LEENA KODALI Charlotte Hall. MD 20622 31. Date filed (Month, Day, Year, State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Kenneth E. Swick Medical Examiner 4a. Facility Name (if not institution, give street and number) City, Town, or Location of Death County of Death MUMBERLAND If Under 1 Year If Under 24 Hrs. 5. Social Security Number . Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Months Days Hours Sept. 28,1936 Director 73 Keyser, WV 233-58-3376 Usual Residence of Decedent 28a-f shov 10a, State 10c. City, Town or Location traumatic event, the Medical Examiner must be notified at Director 10d. Inside City Limits 1 Yes 2 X No WV Mineral Keyser 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? by Funeral 1070 Carolina Avenue 26726 items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces' Black, White, etc. 1 Never Married 2 X Married Page 1 and 2 should be filed within 72 hours after ō 2 | No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White "natural", Completed 3 Widowed 4 Divorced Year or Dates. 1954-58 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene, is marked other than Plastic Bag Elementary/Seconday (0-12) College (1-4 or 5+) **12** Extruder Operator Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, မ Glen H. Swick Hazel Arbutus Bosley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other th Marjorie E. Swick/Wife 1070 Carolina Avenue Keyser, WV 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 M Burial 2 Cremation 3 Removal from State Jan 4 ☐ Donation 5 ☐ Other (Specify) Restlawn Memorial Gardens 2010 LaVale, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Smith Funeral Home 1 Suan 85 S. Main Street Keyser, WV 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death METASTATIC Physician/ disease or condition JAME NON Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Cisease or iinjury that initiated events resulting in death) Last Examiner Due to for as a consequence of: Due to (or as a consequence of): physician s the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 1 Yes 2 L 9 Unknown Unknown P.O. signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 ☐ Unknown Records, Be Completed 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 1 ☐ Yes 2 ☐ No ☐ Yes Division of Vital Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: Certificate: To 1 🗌 Yes 1 Nanpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending within 24 hours after death, Fo the Funeral Director: A: Investigation 6 Could not be 1 Yes 2 🗆 No Accident

Suicide

Homicide Accident Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier D23371 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Qamar Zaman, WMRMC Willowbrook Road Cumberland, MD M.D Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 2 2 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of Ma	aryland / Depa <i>Ce</i> a	artment of H rtificate of L			giene 20	10 01431
	Physic /Medi		1. Decedent's Name (First, Middle, La Obert Stat	e fr				2. Date of Dea Month	Day	Year G.47 P M
	Exami	ner		landMedica	al Center	Balti			4c. County o	f Death
	Funeral Director		5. Social Security Number 6. S 396–12–2370 Usual Residence of Decedent	Sex 7.Ag	e (In yrs. last birthday) 86 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da Dec 3,	y, Year)	9. Birthplace (State or Foreign Country) Wisconsin
	72 hours after death with the Maryland natural", or Items 23a or 28a-f show after Exercitive I wast by recified at	ctor	10a. State 10b. County Maryland Queen A	nne's	10c. City, Town or Lo	cation een Anne				10d. Inside City Limits 1 ☐ Yes 2 ☐ YNo
	with the	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of WI	nat Country?
	death w	Funeral	313 Mason Branch	12. Was Decedent Armed Forces?	Ever in U.S. 13.	216 Was Decedent of Hi f Yes, specify Cuba		pecify Yes or No-	14. Race	ed States - American Indian,
9036	ours after de ral", or Items Examinar in	<u>₹</u>	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 TYes 2 If Yes, Give Year or Dates:	No I	1 □Yes 2 ∑ No	Specify:	o Rican, etc.)	Specify:	, White, etc. White
21215-0036	ithin 72 hours ne. han "natural",	Completed	15. Decedent's Ed (Specify only highest grades) Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5	(Give	dent's Usual Occupa kind of work done d DO NOT use retired	ation luring most of work)	king	16b. Kind of Bus	iness/Industry
	filed w Hygie other tl ent, th	e Co	12 17. Father's Name (First, Middle, Last,)	Me	chanic	18. Mother's Nam	ne (First, Middle,	Rail Maiden Surname	road
Maryland	permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "r amy injury or other traumatic event, the Modone.	To Be	John Herbert		d		Mab			Kent
Mar	id 2 sh Ith and 27 is m traum	0 3	19a. Informant's Name/Relationship (Susan E. Lukas/d	**		ig Address <i>(Street &</i> B ridgetow				
ore,	es 1 ar of Hea of Item 2		20a. Method of Disposition		20b. Place of Dispo			Date Date		ity or Town, State
Baltimore,	t. Page rtment rtant: It		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	y)	Final Jou	rney Crem	atory 1/	7/2010	Woodbin	e, Maryland
Bal	permi Depar Impor any ir			Roman	м00957 В	Name and Addres oing Home everly L.	Crematic	te. P.A.	Clarksv	ille, MD 21029
· K	Physician		23a. Part (Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition	plications that caused one cause on each lin		er the mode of dying	g, such as cardiac	or respiratory ar	rest,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	A	a consequence of):					Zweeks
8	xecuted and I-transit	Examiner	Sequentially list conditions, if any had ingle immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence of):					
68760,	ficate be executed physician and sthe burial-transit	edical E		. d	a consequence cij.	·				
.O. Box (Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □ No 9 □ Unknown	23c. If yes, outcome † ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 ☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)			23d. Date Mont	
rds, P.	w requires that the de been signed by the s should be detached i	þ	Part II. Other significant conditions of	ontributing to death bu	t not resulting in the ur	derlying cause give	n in Part I.	23e. Did to	. /	oute to the cause of death?
of Vital Records,	: The law re cate has be page 2 sho	Completed						24a. Was a autop: perfor	sy pri med de	ere autopsy findings available or to completion of cause of ath? Yes 2 MNo
Vita	sician: The certificate h rector, page	Be	25. Was case referred to medical examiner?	Hospital:		Othe	26. Place of Deat	h (Check only or	ne)	
on of	iding Phys th. After this funeral di	tion: To	1 Yes 2 Mo 27. Manner of Death 1 Matural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day	nt 2 ER/Outpatien y 28b. Time of Injury	28c. Injury Work	4 LJ Nursing Ho		ence 6 Other	
Division	al or Attendin s after death. I Director: Af id in by the fur	Certification:	3 Suicide 6 Could not be determined	_	ry - At home, farm, stre . <i>(Specify)</i>			28f. Location (S City or Tow	treet and Number n, State)	or Rural Route Number,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medical C	29a. Certifier 1	ysician: To the best on niner: On the basis of and manner sta	of my knowledge, death examination and/or invited.	occurred at the tim restigation, in my op	ne, date and place, pinion, death occur	and due to the ored at the time, or	cause(s) and man date and place, an	ner as stated. d due to the cause(s)
		M	29b. Signature and title of certifier MWY HW EWWY	MD		29c. License	number 165	2	1	Month, Day, Year)
	641		30. Name and address of person who a	completed cause of de	eath (Item 23a) (Type, F Z S. Greek	rint) ne Street	Baltimor	e, MD	SIZOI	
	Sta Registr	-	31. Date filed (Month, Day, Year)		r's Signature	arked	-			****

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Januar 7:20AM ew /Medical 4b. City, Town, or Location of Death
Glen Duenie Facility Name (If not institution, give street and number) County of Death Examiner Washington Medical Daltimore ARUNDER ANNE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth | Hours | Min. | (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 ☑ M 2 ☐ F 217-15-8757 Director 12-Cheverly, Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other fraumatic event, the Mydical Eventual must be notified at once. 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits Director 1⊠Yes 2 No Maryland Prince George's Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20781 USA 4707 Edmonston Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☒ No 11. Marital Status 14. Bace - American Indian. 1 X Never Married 2 ☐ Married NOR ANDREW Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify: Specify: White \$ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Retail Department Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert Noel Taylor Amy Marie Peifer ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Noel & Amy Marie Taylor—Parents 4707 Edmonston Road, Hyattsville, MD 20781 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🏻 Cremation 3 ☐ Removal from State Alexandria, Virginia Metropolitan Crematory 1/11/2010 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 4739 Baltimore Avenue laude the. Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** MEDT disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner PNEUMOR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of). P.O. Box 68760, physician Physician/Medical the. attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 icate has been si 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 2 **No** Division of Vital 1 ☐Yes 2 CA 1 ☐ Yes After this certification, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗖 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No after death
Director: / 2 Accident investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide filled in I hours 24 hours Medical 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only To the I within 2. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0055 January 5,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tsion Berhane, 4404 Queensbury Road, Riverdale, MD 20730 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

JAN 0 7

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Bernice Rita Taylor 10:41 A M January 9. 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death St. Mary's St. Mary's Hospital Leonardtown Social Security Number 8. Date of Birth (Month, Day, Year August 15, 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F Days Country)
Maryland 82 Director **1927** 579-32-7918 Usual Residence of Decedent 10a. State 10b. County death with the Maryland 10c. City, Town or Location an "natural", or items 23a or 28a-f sho Medical Examiner must be notified at 10d. Inside City Limits Director 1 🗌 Yes 2 🏿 No Maryland St. Mary's Loveville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 25920 Loveville Road 20656 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc permit. Page 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examir þ 1 Never Married 2 Married 1 ☐ Yes 2 🗷 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. B1ack Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) State Government Social Worker 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Alice D. Shorter Richard White, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Drayden, MD 20630 Wanda M. Cutchember / Daughter 18688 Cherry Field Road 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State January 16, 1 🗷 Burial 2 🗌 Cremation 3 🗌 Removal from State Charles Memorial Gardens 2010 Leonardtown, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses Name and Address of Facility
Mattingley-Gardiner Funeral Home, P
P.O. Box 270 Leonardtown, MD 20650 Jichael Jandine 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician, (erebalascular accidents disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner failure Consestive near Sequentially list conditions, Examine day, leading to immediate cause. Enter Underlying Cause (Disease or linjury Argertension eate has been signed by the attending physician and page 2 should be detached for use as the bunal-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year 1 Yes 2 Volo 9 Unknown 4 Pregnant a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Ceregovascolar Accident 1 Yes 2 No 3 Probably 4 Unknown Cardiomy , path 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific 25. Was case referred to medical examiner? __, 26. Place of Death (Check only one) Be Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🙀 No ည 1 Nopatient 2 ER/Outpatient 3 DOA Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident
Suicide 1 Yes 2 No Investigation completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of 29c. License number

O Plane
State
Registrar

DHMH 17 Rev 7/2009

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dhananjay Bhavsar, MD

JAN 1

31. Date filed (Month, Day, Year)

D61719

5 Garrett Avenue, La Plata, MD 20646

20/0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Vaar **Physician** 10,2010 2:30 P M MELBA V. TAYLOR January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3716 Love Road Darlington Harford If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 7 / 11 / 1930 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Virginia 1 □ M 2 🖸 F 223-38-8298 79 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State d other than "natural", or items 23a or 28a-f show event, the Predical Examination resided at MD Harford Darlington 1 ☐Yes 2 XNo Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number death with 3716 Love Road 21034 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status e filed within 72 hours after de la Hygiene.

other than "natural", or item 1 ☐ Yes 2 [X]
If Yes, Give
Year or Dates: 1 Never Married 2X Married altimore, Maryland 21215-0036 1 ∐Yes 27√2 No Specify. Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Shoe Elementary/Secondary (0-12) College (1-4or 5+) Seamstress Manufacturing and 2 should be filed wiealth and Mental Hygier n 27 is marked other ther traumatic event, Its 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (Carl Funk Linnie Martin ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is n any Injury or other traun James W. Taylor/Husband 3716 Love Road, Darlington, MD 21034 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Bel Air Mem.Gdns. 1/13/2010 Bel Air, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Forer Servicy Lice 22. Name and Address of Facility Harkins Funeral Home, Inc., Delta, Rober PA17314 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Metaltotic /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Box 68760, attending physician Physician/Medical nse 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Month in the past 12 months? Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No P.0. signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has autopsy certificate 1 □Yes 2 No Division of Vital in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \sum Nursing Home \quad \textbf{X} Residence 6 \subseteq Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ပ 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 🖟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10026318

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State Registrar 3445 E BOX Hill Corporate Center Trive,

Abingan and 21009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Norala G. Thornes

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) 1 - For State Registrar Certificate of Death Rea. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** 3:45 a.M Lansing Averett Viccellio January 2010 03. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Rockville Montgomery Caseu House Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 ☑ M 2 ☐ F Months Days Hours Min. Virginia May 06, 1918 Director 224-52-6364 Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Mudfoal Evaminer must be notified at once. 10a State 10b. County 10c. City. Town or Location 1 ☐Yes 2 🕅 No Director Silver Spring Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 20904 312 Apple Grove Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: 195 14. Race - American Indian. 11 Marital Status 1 ☐ Never Married 2 ☐ Married 1936 1958 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🎗 No Specify ģ Caucasian 3 Nidowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Johns Hopkins University Elementary/Secondary (0-12) College (1-4or 5+) Senior Engineer Applied Physics Lab. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Minnie Averett Hodaes Henry Viccellio, Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 312 Apple Grove Road, Silver Spring, Maryland 20904 Phyllis Lee Viccellio-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arlington Natl. Cem. | 02/03/2010 Arlington, Virginia HO # 1070 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service Licensee 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Congestive Heart Failure /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Emer underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physician: The law requires that the death certificate be executed burial-transi and Due to (or as a consequence of) physician the burial Physician/Medical as IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify) signed by the a Ö 9 Unknown 9 Unknown σ. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, ò 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 【 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page perform rmed? 2 🖸 No 1 □ Yes 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 DOther (Specify) HOSPICE 1 ☐ Yes 2 🗓 No 1 Inpatient 2 ER/Outpatient 3 DOA After this Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Division or Attending 5 Pending investigation 1 X Natural To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b, Signature and title of certifier chou . KOUCE 263748 XI January 04, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D., 6001 Muncaster Mill Road, Rockville, Maryland 20855 Jocelyne T. Kouatchou, 32. Registrar's Signatur 31. Date filed (Month, Day, Year) State JAN 06

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Lillian Kathleen Warehime 01/02/2010 1815 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Dove House Westminster Carrol] 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 01/19/1921 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 🛈 F MD 199-05-9127 88 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Medical Examinating the multilled at 1 ☐ Yes 2 XNo Director Carroll MD Westminster 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1113 Stone Road 21158 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. <u>م</u> 3 Widowed 4 □ Divorced White
16b. Kind of Business/Industry Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Deli Clerk A&P 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Washington Stem Cora Carr ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Karl E. Warehime 1107 Stone Rd. Westminster MD 21158 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 01/06/2010 Westminster MD Pleasant Valley Cem. 22. Name and Address of Facility Pritts Funeral Home and Chapel P.A. 21. Signature of Funeral Service Ligenses 412 Washington Road, Westminster MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 🗌 Ectopic pregnancy Month Year Day in the past 12 months? Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f ☐Yes 2X No Division of Vital Records, P.O. 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown After this certificate has been s funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐Yes 2 ☐No 1 □Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Mother (Specify Hospital: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes Certification: To 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No n 24 hours after death.

e Funeral Director: A sletely filled in by the fi 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical **Tpletely** To the within 2 29d. Date signed (Month, Day, Year) 29c. License number MD pleted ca se of death (Item 23a) (Type, Print) 30. Name and address of person WESTMINSTERHOZIIST Alle FHALIL 295 SHONER 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

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Registrar

Phys /Me Exar

Funer Direct

		1 - For State Registrar	State of Marylan	d / Depa			1ental Hyg	•	01437
icia dica		Decedent's Name (First, Middle, Last) Mary Jean	White				2. Date of Dea Month Janua	Day Year	3. Time of Death
nine		4a. Facility Name (If not institution, give an ANCHORAGE NURSING	& REHABILITAT		SALI	SBURY		4c. County of Deat WICOMI	co
al or		5. Social Security Number 6. Septimber 218-24-4641	7. Age (In yrs.)	Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day 04/04/		hplace (State or Foreigr untry) aryland
	Tor	10a. State 10b. County Maryland Wicomic		y. Town or Lo lisbur					10d. Inside City Limits 1 XYes 2 No
	al Direc	10e. Street and Number 105 Times Square			10f. Zip Code 2180	1		10g. Citizen of What Co USA	untry?
	Completed by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1	Was Decedent of I If Yes, specify Cub	Hispanic Origin? (Sp pan, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: wh	e, etc.
	mpietea	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e <i>completed)</i> College (1-4or 5+)	(Give life.	dent's Usual Occup kind of work done DO NOT use retire Sewife	pation during most of work ed)	ing	16b. Kind of Business	Industry
	o ge Co	17. Father's Name (First, Middle, Last) Bishop Messick		nou	Sewife		e (First, Middle, Mae Redo	Maiden Surname)	
	:3	19a. Informant's Name/Relationship (Type Robin L. Meadows/			-	st., Pitt		r, City or Town, State, 2 MD 21850	Zip Code)
		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specify)	emoval from State	emetery, crer	sition (Name of natory or other pla cy Cremat	ice)	Date	20c. Location - City or Salisbury	
S C	Ţ	7. Signature of Funeral Service License	CFSP	50	Ol Snow H	Hill Rd.,	Salisbu	essional As ry, MD 2180	ssociation)4
n al er	Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Finat disease or condition resulting in death) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ	uence of):					Approximate tnterval Between Onset and Death
	Completed by Physician/Medical	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of do 9 ☐ Unknown	death 3⊡ ∋ath 5⊡	Ectopic pregnanc Other (specify)	,		23d. Date of det Month	ivery Day Year
	leten by r	Part II. Other significant conditions con	j	ulting in the u	nderlying cause gr	ven in Part I.	23e. Did to		the cause of death? obably 4 Unknown topsy findings available
		25. Was case referred to medical	1/15/405				autops perfor 1 Yes	sy prior to death? 2 No 1 ☐ Yes	completion of cause of 2 12 No
	2	examiner? 1 Tes 2 No 27. Manner of Death	28a. Date of Injury	ER/Outpatien	28c. Inju	ry at	me 5□Resid	ence 6 Other (Specow injury occurred	cify)
1000	medical certification:	1 Natural 5 Pending 2 Accident 3 Suicide 6 Could not be determined	(Month, Day Year) 28e. Place of tnjury - At ho building, etc. (Specify	Injury me, farm, str		Yes 2□No	28f. Location (S City or Tow	treet and Number or Ru n, State)	iral Route Number,
	onical C	29a. Certifier (Check only one) 12 Certifying Physical Examination (Check only one)	sician: To the best of my knor ier: On the basis of examinat and manner stated.	wledge, death tion and/or inv	n occurred at the ti vestigation, in my o	me, date and place, opinion, death occurr	and due to the cred at the time, d	ause(s) and manner as late and place, and due	stated. to the cause(s)
	ME	29b. Signature and title of certifier walking was				zo/4	2	29d. Date signed (Monte	h, Day, Year)
	1	30. Name and address of person who co	mpleted cause of death (ttem	23а) (Туре,	Print)	Enla 1	cal.	f	1 2/1/1/

DHMH 17 Rev 1/2001

State

Registrar

31. Date fited (Month, Day, Year)

JAN 08 2010

32. Registrar's Signature

Physician /Medical Examiner Examine

permit. Pages Department of H Important: If ite any Injury or of

Physician

/Medical

10a. State

Examiner

Funeral

Director

or 28a-f show be notified at

item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be

Director

Funeral

þ

Completed

Be

with the Maryland

filed within 72 hours after

Pages 1 and 2 should be

Saltimore, Maryland 21215-0036

Physician/Medical Be Completed Certification: To

þ

Medical

State Registrar

26423

31. Date filed (Month, Day, Year)

IF FEMALE:

physician and the burial-tran as the use ō ate has been signed by the page 2 should be detached To the I

Division or Vital Records, P.O. Box 68760.

1 □ Yes 2 No 9 □ Unknown	4∐Pregnant at time of death 9⊡Unknown	5 ☐ Other (specify)		,
Part II. Other significant condition	s contributing to death but not resulting in	n the underlying cause given in Part I.		use contribute to the cause of death? No 3 □ Probably 4 □Unknown
			24a. Was an autopsy performed? 1 Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
25. Was case referred to medical		26. Place of D	eath (Check only one)	
examiner? 1 ☐ Yes 2 █ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Ou	utpatient 3 DOA Other: 4 Nursing	Home 5 ☐ Residence	6 ☐Other (Specify)
27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigat	(Month, Day Year)	Time of Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how inju	ry occurred
3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		arm, street, factory, office	28f. Location (Street at City or Town, State	nd Number or Rural Route Number, e)
29a. Certifier 1 Certifying (Check only one)	Physician: To the best of my knowledg kaminer: On the basis of examination ar and manner stated.	e, death occurred at the time, date and pland/or investigation, in my opinion, death of	ce, and due to the cause(s	s) and manner as stated. d place, and due to the cause(s)
29b. Signature and title of certifier		29c. License number	29d. Da	ate signed (Month, Day, Year)

1)0015715

1.6.10

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Burron Avr

JAN 07

bustriel,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ Willey Mary Etta ANUMRY Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Wicomico Peninsula Penional Medical Center alisbur 9. Birthplace (State or Foreign Country) Delaware 8 Date of Birth **Funeral** 08/05/1 214-30-8597 78 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State Director 1 ☐ Yes 2X No Fruitland Wicomico Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 21826 3286 Phillips Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11, Marital Status Armed Forces? Black, White, etc 1 Never Married 2 Married þ 1 ☐ Yes 2 🔀 No Specify: white If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) food 12 retail Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Mary C. Warrington Dallas M. Elliott 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zig 3286 Phillips Rd., Fruitland, MD 21826 19a. Informant's Name/Relationship (Type, Print) Levi Willey Sr/spouse 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Date Dorchester Memorial 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 1/9/10 Cambridge, MD 4 Donation 5 Other (Specify) Park 21. Signature of Funeral Service Lice ee 22HOTIOWAY Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition Physician Medical resulting in death) Due to (or as a consequence of) Examiner ASCVD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Quet de as e popsequence of sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed AFIB that initiated events resulting in death) Last Due to (or as a consequence of) been signed by the attending physician should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy5 ☐ Other (specify) ____ Day in the past 12 months? Month Year Pregnant at time of death 2 No Yes Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? Director: After this certificate | 1 Tes Yes 2 No completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 🗌 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, မ 27. Manner of Death 28a. Date of injury 28b, Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) injury work? 1 ☐ Yes 2 ☐ No Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number determined City or Town, State) To the Hospital or within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month. Dav. Year) 29b. Signature and title of certifier D57952 01/06/2010

Registrar

Babulal

106 Mil ford ST

32. Registrar's Signature

405 B. Salisbury

MD21804

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

Day,

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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		For State		,	State o	t Maryla	and /	-	ırtmen <i>tificati</i>		lealth an Death	nd Me		giene Reg. No	0.0	In	\cap	11.1.0
		Registrar 1. Decedent's Name	e (First, Middle	e, Last)	_			00/	imoun	0. 2	- Cut. 1	T	2. Date of De			Year		e of Death
Physicia Medic	cal	Phyllis			A				Wilk				0/	00	1 0	2010	18	56 M
Examin	er	4a. Facility Name (if		-		noer) Nedik	al C	·~	4b. City,	Town, or	Location of D	Death SM	WCI	40	c. County	of Death	NCC	۷
Funeral		Social Security Nu	umber	6. Sex		7. Age (In yı	s. last bir	thday) Yrs.	If Under Months	1 Year Days	If Under 24 Hours	Hrs. Min.	8. Date of Bird (Month, Da 2-9-19	th y, Year)		Cour	ntry)	te or Foreign
Director		511-24-59 Usual Residence of	Decedent			78							<u> </u>	31_			isas	
a-f sho	Director	10a. State	10b, County				City, Tow										_	e City Limits Yes 2 \Backsquare No
the Manner or 28 se noti		MD 10e. Street and Num	Wicom	1100			Salis	sbur	y 10f. Zip	Code				10g. C	itizen of V	Vhat Cou		
th with ns 23g must b	Funeral	105 Kenal	1 Stre					1		2180		0.40			US			
or iter	by Fu	11. Marital Status1 ☐ Never Marri	ied 2 🗆 Mai		Armed For	2 💢 No	0.5.	If	Yes, spec	ify Cuba	ispanic Origin' In, Mexican, P	7 (Spec Juerto R	ican, etc.)		Blac	k, White,		1
ours aft tural", al Exa	ted	3 🄀 Widowed ⁴			If Yes, Give Year or Da						Specify:					Whi		
ר 72 hc an "na Medic	Completed	(Spec	15. Decede			-1 or 5+)	168	(Give k	ent's Usua aind of wor NOT use	k done a	ation during most of	working	g	16b. k	Kind of Bu	usiness In	dustry	
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be file ental H ked of ic ever	To B	17. Father's Name (F	First, Middle, .	,	Willi	am		P	otee		18. Mother's Gladys		(First, Middle,	Maiden Faye)	Este:	s
should and M is mai		19a. Informant's Na	me/Relations				198			(Street a	and Number o					tate, Zip		
and 2 Health em 27 ther tr		Lonetta S 20a. Method of Disp		- Gr	andda				Cente		treet,		itland				21826 own, State	
Page 1 lent of nt: If it ry or o		1 🔀 Burial 2 [4 🗋 Donation	☐ Cremation		moval from	State	cemete	ery, crem	natory or o	ther plac	e) Gds 1					,		
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amportant: If item 27 is marked other than "natural", or items 23a or 28a-f show important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Fur			,	D0	1	22.	. Name an	d Addres	ss of Facility	Bou	nds Fu	nera	al Ho	me		
<u>0</u> 0 = 00		23a. Part 1. Enter to	he disease, o	r complica	tions that o	Deak aused the d	eath. Do				in Stre				y , Ma	ıryla İ	nd 2 Approxi	
Physician/		shock, or hear Immediate Cause (I disease or conditio	rt failure. List Final	only one c	use on ea	ch line.				· - y · · ·	g,		,	,			Interval	Between nd Death
Medical Examiner		resulting in death)	n I	C a	_	Or as a cons		of):			·					\dashv		
	Jer	Sequentially list cor if any, leading to im	nmediate	b	Due to (CUM (I	V/A- equence	of):								\dashv		
executed ian and urial-transit	Examiner	cause. Enter Under Cause (Disease or i that initiated events	iinjury s	C		UNG												
be exe sician a burial d	l= 1	resulting in death) L	Last	L		or as a cons	equence	of):										
ificate ig phys as the	Physician/Medica	IF FEMALE:		d. ,														
ath cert attendir for use	ian/I	23b. Was decedent in the past 12 r	months?	23c	1 Live	come of pre Birth 2 🗆 I nant at time	etal deat		Ectopic		;y				23d. Da	te of deliv	ery Day	Year
the dea by the a ached t	hysic	1 Yes 2 L 9 Unknown			9 Unkr		or death	3 L	other (st	еспу)			1					
es that igned to be det	ρ	Part II. Other signif	icant conditi	ons contri	buting to d	eath but not	resulting	in the u	nderlying	cause giv	ven in Part I.		23e. Did to					of death?
requin been s should	Completed												24a. Was		<u> </u>			gs available
The law ate has bage 2	omo													psy ormed? 2 2 N	(death?	mpletion of	of cause of
ician: Sertifica ector, p	Be	25. Was case referre examiner?		Hos	pital: _					Oth	ace of Death (Check (
g Phys er this c	e: To	27. Manner of Death			1 L 28a. Date	Inpatient 2 of injury	28b.	Time of		OA 28c. Injury	4 ∐ Nursi y at		ne 5 Resid Bd. Describe h				v)	
tending leath. or: Afte the fun	Certificate:	1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide	5 Pendi Invest 6 Could	igation	(IVION	th, Day, Year		injury	М	work 1 🗆	Yes 2 No	0						
after of Direct Jin by		4 Homicide	determ			of Injury - A ng, etc. (Spe		arm, stre	et, factor	, office		2	8f. Location (S City or Tow			er or Rure	l Route Nu	imber,
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death certificate has been signed by the attending physici To the Luneral Director. After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu	Medical										, date and place							manner stated.
o the livithin 2. o the liconthe liconthelet	Me		Certifying	g Nurse P					eath occu	rred at the	e time, date an e number			e cause	(s) and ma	nner as s		
·		•	Chri	MO						0.5	0929				_			
18A		30. Name and addre	ess of person	who com	oleted caus		tem 23a)	(Type, P	rint)		5T.	CY	11001	2	iAe	n .	,01	()
Stat	te	31. Date filed (Month	h, Day, Year)	Lb	32. R	190. egistrar's Sig	gnature	1. U	111	ION	3/-	JA	VINBU	KY	, en	2_~	180	
Registra	ar		JAN 0"	7 201	1 /4	mur	p.	19	wie							_		

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State of Maryland / Department of Health and Mental Hygiene

			State of Maryland / D	epartment of Health and N	Mental Hygiene	
		_	1 - State Registrar	Certificate of Death	Reg. No.201) () [44]
	Physicia	n/	1. Decedent's Name (First, Middle, Last)		Date of Death Month	3. Time of Death
	Medic		Frank H Waring		1 11 201	D 1348 M
	Examin	er	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Dea	ath C
			5. Social Security Number 6. Sex 7. Age (In yrs. last birth	day) If Under 1 Year If Under 24 Hrs.	8. Date of Birth 9. Bi	rthplace (State or Foreign
	Funeral Director		700 1/ 5005 www.off	rs. Months Days Hours Min.	May 9, 1925 Con	necticut
	_		Usual Residence of Decedent		rady 9; 1929 point	
	land show	to	10a. State 10b. County 10c. City, Town			10d. Inside City Limits
	Mary 28a-f otifie	irec	MD Wicomico Sa	lisbury	· · · · · · · · · · · · · · · · · · ·	1 K Yes 2 □ No
	ould be filed within 72 hours after death with the Maryland dd Mental Hygiene. marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at	Completed by Funeral Director	10e. Street and Number 31888 Bonhill Drive	10f. Zip Code 21804	10g. Citizen of What C United S	
	eath v	ın.	11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (Spe		
ထ္ထ	ter de , or il imine	by	1 ☐ Never Married 23☐MMarried Armed Forces? 1 ☐ Never Married 23☐MMarried 1 ☐ No	If Yes, specify Cuban, Mexican, Puerto	Diack, Will	_{te,etc.} Vhite
8	ursal ural" al Exa	ted	3 ☐ Widowed 4 ☐ Divorced If Yes, Give 143-45	1 ☐ Yes 2 🛣 No Specify:	Specify: V	AIIICE
2	72 ho	ed l	(Specify only highest grade completed)	Decedent's Usual Occupation Give kind of work done during most of work	ing 16b. Kind of Business	Industry
12	tthin the M	등		ife. DO NOT use retired) onsultant	Railroa	ds
0 0	ed wi Hygir Sther ent, t	Be (17. Father's Name (First, Middle, Last)		e (First, Middle, Maiden Surname)	
Maryland 21215-0036	d be fill	욘	Frank Hays Waring, Sr.	Henrie	tta von Dohlen	
lan,	ਲ ਸ਼ਾਲ ਭਾ			Mailing Address (Street and Number or Rura		
	and 2 s Health tem 27 other tra		0, 1	888 Bonhill Drive, S		
ore	~ 0		1 Burial 2 Cremation 3 Removal from State cemetery	crematory or other place)	Date 20c. Location - City o	
Baltimore,	permit. Page Department Important: any injury o				30/10 Cokesbur	
Ba	permit. Page Department Important: I any injury o	-	21. Signature of Funeral Service Licensee Wasture M. Coale	22. Name and Address of Facility Fra 216 N. Main St., Fe	amptom Funeral Hom ederalsburg, MD 21	ne, P.A. 632
П			23a. Part 1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause — each line.	t enter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between
P	nysician/		Immediate Cause (Final disease or condition	Artus Di	lease	Onset and Death
	Medical Examiner		resulting in death) a. Du to (or as a consequence of		1	
		<u>.</u>	Sequentially list conditions, b.	re Heart T.	2. lune	
_	sit sit	Examiner	If any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	i:		
	death certificate be executed ne attending physician and ed for use as the burial-transit	Еха	that initiated events resulting in death) Last C. Due to (or as a consequence of);		
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89	certit inding use a	2	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	2 - Feteria - vernancy	23d. Date of d	elivery
Вох	leath e atte d for	icia	in the past 12 months? 1	5 Other (specify)	Month	Day Year
	the c by the tache	Physician/Me	9 Unknown			
<u>.</u>	s that gned be de	by	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobacco use contribute t	
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000	law re nas be e 2 sh	Completed	Tayte (Cenal tailune	1	autopsy prior to	utopsy findings available completion of cause of
Re	cate t	Co			performed? death? 1 Yes 2 No 1 Yes	es 2 No
ta .	ician certifi ector	Be	25. Was case referred to medical examiner?	26. Place of Death (Check		
<u> </u>	Phys this c	٠ <u>.</u>	1 Ves 2 No rospital: Annatient 2 ER/Out 27. Manner of Death 28a. Date of injury 28b. Ti	patient 3 DOA 4 Nursing Ho	ome 5 Residence 6 Other (Spe 28d. Describe how injury occurred	cify)
Division of Vital Records,	ding th. : After : fune	Certificate:		ury work? M 1 Ves 2 No	200. Describe flow injury occurred	
Sio	Atter	rtifi	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm	n, street, factory, office	28f. Location (Street and Number or R	ural Route Number,
2	tal or rs afte al Din ed in		building, etc. (Specify)		City or Town, State)	10
	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. within 24 hours after death. completed filled in by the funeral director, page 2 should be detached for use as to completed filled in by the funeral director, page 2.	Medical	29a. Certifier (Check Check 1 Certifying Physician: To the best of my knowledge, d 2 Medical Examiner: On the basis of examination and/or	investigation, in my opinion, death occurred a	t the time, date and place, and due to the	cause(s) and manner stated.
	o the vithin 2 or the comple	ž	only one) 3 Centifying Nurse Practioner: To the best of my knowle 29b. Signature and title of centifier			
	⊢≯řŏ			29c. License number 3474	08	
			30. Name and address of person who completed cause of death (Item 23a) (To	ype, Print)	[-11	21501
			Referen Wieland, M.D. 7	P.R.M.C. 100 F.C.	arroll St Salis	2010 21801 bury mD
	Sta	le	31. Date filed (Month, Day, Year) 22. Registrar's Signature	t-ul		
	Registra	ar	JAN 1 5 2010 Langua A.	acre		

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Registrar Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JANUARY 2010 55 ANN Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b, City, Town, or Location of Death 4c. County of Death FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Pennsylvania Funeral 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Days **Director** 177-16-7941 88 March Usual Residence of Decedent 10a. State 10b. County or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director Frederick Marvland Frederick XX Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 119 West 14th Street 21701 U.S.A. and 2 should be filed within 72 hours after death 12 Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 X No 1 Never Married 2 X Married þ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify Specify: White 3 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Francis Willard Horne Iva McMillen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health a Lewis Paul Wade, son 137 East Third Street, Frederick, MD 21701 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of H Important: If Ite any Injury or ot once. Resthaven Mem. Gardens Jan. 16, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2010 Frederick, MD 21. Signature of Funeral Service Licensee Keeney and Basford PA Funeral Home 106 East Church St., Frederick, MD M00255 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Pneumonia days disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner com licated by ingestion and aspiration Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner pue to for as a consequence on sician and bunial-transit Cause (Disease or iinjury that initiated events laundry detergent Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? detached for Month Pregnant at time of death the 9 Unknown 9 Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, Dementia 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🔲 No မ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 1/04/2010 Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funeral Natural 5 Pending 4:30A work? 1 ☐ Yes 2 🔀 No Accident ingested Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) a.t. home 28f. Location (Street and Number or Rural Route Number, City or Town, State) 119 W 14th St determined To the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 only one) certifer 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) D51643 1/13/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

Hiren Shah

31. Date filed (Month, Day, Year)

JAN 2 2 2010

65 C

Frederick, Md.

21702

Thomas Johnson Dr.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month BARBARA ANN WOMBLE WILSON Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE'S 10114 CAMPUS WAY SOUTH #102 UPPER MARLBORO Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min (Month, Day, Year) Country) 68 Director 230-52-9645 VIRGINI PRII Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland notified at Director 1 X Yes 2 No MD PRINCE GEORGE'S UPPER MARLBORO 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? iral", or items 23a o Examiner must be Funeral USA 10114 CAMPUS WAY SOUTH # 20774 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2x No Specify. Specify: BLACK "natural" 3 Widowed 4X Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) 12TH College (1-4 or 5+) MASTER BARBER PRIVATE Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F permit. Page 1 and 2 should be fili Department of Health and Mental Important: If item 27 is marked c any injury or other traumatic eve မ M. HAYES SYLVIA CHARLES FRANK WOMBLE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5 JODYS WAY HAMPTON, VIRGINIA 23666 19a. Informant's Name/Relationship (Type, Print) FRANCINE M. WOMBLE/DAUGHTER Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 DeBurial 2 Cremation 3 Removal from State HAMPTON MEMORIAL GARDEN 1/9/10 4 Donation 5 Other (Specify) HAMPTON, VIRGINIA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, it any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): and I-transit Exam Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last physician a s the burial-Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Pregnant at time of death the 9 Unknown 9 Unknown Records, P.O. signed by i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗗 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 1 Yes 2 No Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 5 Pending neral Director: A 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 \square Homicide determined City or Town, State) To the Hospital within 24 hours a To the Funeral C completed filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 001 Date filed (Month, Day, 32. Registrar's Signature **JAN 0 8**

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Dav Month **Physician** an 2010 atricia /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Medical nmo 9. Birthplace (State or Foreign Country)
Illinois 8. Date of Birth (Month, Day, May 30 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Min. Months Days Hours 1 □ M 2 🔀 F 56 1953 May **Director** 108-42-3201 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show the Medical Examinant rust be notified at 1 X Yes 2 No Director MD Kent Galena 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō 23a 228 Phelps Ave. 21635 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 □ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) hours after 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 ☑ No Specify: White Specify: <u>Ş</u> 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the Mental Injury or other traumatic event, the Mental Injury or other traumatic event, the Mental Injury or other traumatic event, the Mental Injury or other traumatic event, the Mental Injury or other traumatic event. Elementary/Secondary (0-12) College (1-4or 5+) Cashier Retail Grocery Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John J. O'Connor Elizabeth Dorman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) James D. Werther, Sr. (husband) 228 Phelps Ave. Galena, MD. 21635 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 1/15/201d Kent Cremation 4 □ Donation 5 □ Other (Specify) Smyrna, DE. 22. Name and Address of Facility
Galena Funeral 21. Signature of Funeral Service Licenses Galena Funeral Home of Stephen L 118 West Cross St. Galena, MD. 2 M00510 21635 Approximate Interval Between Onsetvand Death 23a. Part En if the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final **Physician** disease or condition resulting in death) SPICATO /Medical Due to (or as a conse juence of): Examiner amyo Soundfully list of dillurs if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed burial-trans and Due to (or as a consequence of) Box 68760. attending physician Physician/Medical the as IF FEMALE: use 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Tectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 No 5 ☐ Other (specify) 4 ☐ Pregnant at time of death signed by the a P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed certificate has been rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? Was an autopsy performed? 24a. Was an 2 No 1 ☐ Yes 1 □ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 2 No Hospital: 1 ☐ Yes 1 Inpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA Certification: To After this 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A 2 Accident completely filled in by the 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) dd 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

10-00193 Margie Yung-Kwai Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2010 01445

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28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29a. Certifier (Check only or Town, State) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated and manner stated. 29b. Signature and title of certifier 29c. License number O.C.M.E. January 8, 2010 30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	on rendin sath. or: A	흹	Natural 5 Pending		1 Yes 2	No No			
29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated one) 29b. Signature and title of certifier O.C.M.E. January 8, 2010 30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	'급 등 중 등 시	ertifica	3 Suicide 6 Could not be determined (Specify)	arm, street, fa	actory, office building	g, etc.		and Number of	Rural Route Number, City
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Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201		2	Limite The Man (M)			ber			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 01446 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Thomas E. Adams January 201**0**° 9:51P. Medical 4a. Facility Name (if not institution, give street and number)
Holy Cross Hospital 4b. City, Town, or Location of Death Silver Spring Examiner County of Death
Montgomery . Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days Min. Aug 20 1929 1 M 2 □ F 388-26-0967 80 Massächusetts Director Usual Residence of Decedent "natural", or items 23a or 28a-f show sdical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director Maryland Prince George's Silver Spring 1 🗆 Yes 2 🗓 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3158 Gracefield Road, #614 20904 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Divorced 4 Divorced Year or Dates. Korea the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) other than College (1-4 or 5+), Elementary/Seconday (0-12) Page 1 and 2 should be filed within ment of Health and Mental Hygiene. Electrical Engineer Federal Government 27 is marked othe traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Thomas Adams Grace Holmes permit. Page 1 and 2 shoul
Department of Health and I
Important; If item 27 is ma
any injury or other traums
once. 19a. Informant's Name/Relationship (Type, Print) Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JoAnn M. Adams -wife 3158 Gracefield Rd.,#614 Silver Spring, MD 20904 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metropolitan Crematory 1/6/2010 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Virginia 21. Signature of June 11 Service Licensee Bönarad V. Börgwardt Funeral Home, 4400 Powder Mill Road Beltsville, Maryland20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Acute Myocardial Infarction disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Coronary Artery Disease vears Sequentiary list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) the burial-transi Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as IE EEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) for in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No the 9 Unknown 9 Unknown ate has been signed by ti page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? certificate 1 Yes 2 X No Yes Be 25. Was case referred to medical the funeral director. 26. Place of Death (Check only one) Hospital Other: 1 ☐ Yes 2 X No 2 1 Nnpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 5 Pending after death. Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide completed filled in by determined City or Town, State 24 hours a Medical 🖆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one 29b. Signature 29c. License number 29d. Date signed (Month. Day. Year) 41 marer 10 D019170 January 6, 2010

Registrar

State

M.D. 1400 Forest Glen Road, #200 Silver Spring, Maryland 20910

30. Name and address of person who completed cause of death (tern 23a) (Type, Print)

Alan Kermaier,

JAN

31. Date filed (Month

			Please Type of amend item 10e State	r Print in I per in of Marylan	Black II g900 d / Depa	ndelible Ink artment of H	C Ensure A lealth and N	All Copies . Mental Hygi	Are Leg	gible.	01667
		-	State Registrar AMEND#5per INF, 1/19/10			rtificate of E			g. No.		01447
	Physicia	n/	1. Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day	Year	Time of Death
	Medic	al	David T. Abell 4a. Facility Name (if not institution, give street and nu	mborl		At City Tours or	Location of Dooth	January	6, 20		1:50 a ^M
	Examin	er	Manor Care of Potomac	mber)		Potomac	Location of Death		4c. County	of Death	
	Funeral		Social Security Number 6. Sex	7. Age (In yrs. la	st birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		9. Birthplace	(State or Foreign
	Director		211 30 1307	75	Yrs.	Months Days	Hours Min.	03/18/19	34	Egypt	
)	nd thow at	o.	Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	cation				10 d . li	nside City Limits
-	faryla 8a-f s tified	ect	Maryland Montgomery	Pot	omac					1	X∑ Yes 2 □ No
	the N	Funeral Director	10e. Street and Number 10900			10f. Zip Code		10	g. Citizen of	What Country?	
	h with nust l	nera	-11900 Broadgreen Terrac	е			20854			USA	
	r item iner n		Armed F		3. 13.	Was Decedent of His If Yes, specify Cubar	spanic Origin? (Spe n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		ce - American In ck, White, etc.	dian,
920	s after ral", o Exam	d by	1 ☐ Never Married 2 ★ Married 1 ☐ Yes If Yes, G 3 ☐ Widowed 4 ☐ Divorced Year or D			1 ☐ Yes 2X No	Specify:		Specify	Whit	e
2	hour hatur dical	Completed	15. Decedent's Education (Specify only highest grade completed	7-3		dent's Usual Occupa kind of work done d		ing 1	6b. Kind of B	lusiness Industr	y
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Maryland 21215-0036	ed wit Hygie other ent, th	Be	17. Father's Name (First, Middle, Last)	4	Eleci	rical Eng		ne (First, Middle, Ma	Engine Biden Surnam		
<u>a</u>	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Health and Mental Hygiene. The marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	P	Morris Abdel-Wahed				Miriam			-7	
ary	should and N is ma		19a. Informant's Name/Relationship (Type, Print)		19b. Maili	ng Address (Street a	and Number or Run	al Route Number, C	City or Town,	State, Zip Code)	
Σ.	nd 2 s lealth m 27 ner tra		Morris Abell, son			Iron Ore	· · · · · · · · · · · · · · · · · · ·				
			20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from			osition (Name of matory or other place				- City or Town, S	
Baltimore,	permit. Page Department of Important: If any injury or once.	- 3	4 Donation 5 Other (Specify) 2/. Sign type of Funeral Survice Licensee	Mou		anon Ceme		07/2010 2	Adelph	i, Mary.	Land
Ba	Depart Impo		Turelar Service Elcensee	MO12	55 É	BWARD SAC	EL FUNER	AL DIRECT	FION:	INC. Marylan	d 20852
			23a. Part 1. Enter the disease, or complications that shock, or heart failure. List only one cause on e	caused the death						App	oroximate erval Between
~	Physician/		Immediate Cause (Final disease or condition Pane	creatic	Carcin	oma					set and Death
	Medical Examiner		resulting in death) Due to	o (or as a consequ	ience of):						
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<u>~</u>	in: Th tificate or, pa	Be Co	25. Was case referred to medical			26. Pla	ace of Death (Chec	1 Yes 2	X No	1 Yes 2	No
Ĭ	ysicia lis cer direct	To B	examiner? 1 Yes 2 No Hospital:	Inpatient 2	ER/Outpatie	Othe	or.	ome 5 Resider	ice 6 🗆 Oth	er (Specify)	
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Division of Vital Records, P.O.	alor A s after l Dire		4 Homicide determined	ling, etc. (Specify)	,,		City or Town,		0, 110,41,1104	,
	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. within 24 hours after death. To the Funeral Director, After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu	Medical	29a. Certifier 1 Certifying Physician: To the (Check 2 Medical Examiner: On the base)								and manner stated.
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	15 °		Prnky Single	\cup			57458		1/6		/
			So. Name and address of person who completed car	ase of death (item		Print)			/ /		
			Dr. Pinky Singh, 6502 K			, Riverda	1e, MD 20	737			
	Stat	te	31. Date filed (Month, Day, Year) 32.	Registrar's Signat	ture	23					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
 Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ January 2°, 2010° 10:32 A M Medical Richard Howarth Ashley 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Anne Arundel Medical Center Annapolis Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours 3/9/1930 Director 578-36-9707 79 Washington, Usual Residence of Decedent show 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland Director Maryland Anne Arundel Edgewater 1 🗆 Yes 2 🔼 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 21037 USA 3305 Leritz Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🗓 No Black, White, etc. Completed by 1 Never Married 2 X Married 1 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", Specify 3 Divorced White Year or Dates it of Health and Mental Hygiene.
If item 27 is marked other than "natur or other traumatic event, the Medical or 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Builder Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Richard S. Ashley Howarth Annette 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stealey J. Ashley/ Wife 3305 Leritz Lane, Edgewater, MD 21037 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Kalas Crematory 1/5/10 Edgewater, MD . Signatur Al Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death 5 Other (specify) 1 Yes 2 9 Unknown 4 ☐ Pregnam
9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 1 Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No completed filled in by the funeral director. Be 26. Place of Death (Check only one) Other: မ 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation within 24 hours after deat To the Funeral Director: 6 Could not be ☐ Sulcide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signatu License number 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of pe

31. Date filed (Month, Day, Year

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n who completed cause of death (Iten 23a) (Type, Print)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 0 1 4 4 9 1 - For Stata Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year 2010 5354M Frederick W Blair 0 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Washington Hagerstown MS Healthcare of Hajersburn If Under YYear | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Buthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Days Hours 1⊠M 2□ F 88 217-16-2630 May 5 1921 Maryland Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 X Yes 2 □ No Maryland Washington Hagerstown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 14014 Marsh Pike 21742 IISA 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 M Yes 2 No If Yes, Give T Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: WW 11 White 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 0 Lineman Electric Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Russell Stanley Blair Venetta Grosh 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Janet Manning - Daughter 11 W. Baltimore St. Apt. 105 Hagerstown, Md. 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ∏Burial 2 □ Cremation 3 □ Removal from State * 4 ☐Donation 5 ☐ Other (Specify) Rest Haven Cemetery 1/12/2010 Hagerstown, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Minnich Funeral Home May Ames 11 415 E. Wilson Blvd. Hagerstown, MD. 21740 23a. Part Lenter the diseasa, or amplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) Jementia Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 □ Ectopic pregnancy Month Dav Year 4☐Pregnant at time of death 5 Other (specify)

permit. Pages 1 and 2 should be filled. Department of Health and Mental Health portant: if item 27 is meany injury or other. **Physician** /Medical Examiner

Physician

/Medical

Examiner

Director

Completed by Funeral

Be ٥

Funeral

Director

item 27 is marked other than "natural", or items 23a or 28a-1 show other treumatic event, the Medical Examinar must be notified at

and Mental Hygiene.

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Examiner attending physician and for use as the burial-transit use as the cate has been signed by the page 2 should be detached certificate

The law requires that the death certiticate be executed

Attending Physicien:

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completely

Division of Vital Records, P.O. Box 68760,

Physician/Medical Be Completed by : After this certifica e funeral director, p Medicai Certification; To

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

29a. Certifier

arau

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 2 No 1 ☐ Yes

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 No Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural
2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No

investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

28f. Location (Street and Number or Rural Route Number, City or Town, State) Teartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier

29c. License number R11857

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hajerstown

WH- 241 State Registrar

31. Date filed (Month, Day, Year)

JAN 1 1 2010



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Smith Walker Bagley January 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Montgomery County Bethesda Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign New York 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Days Hours Months April th Of 1935 110-30-3594 74 Director Yrs Usual Residence of Decedent 28a-f show 10a. State 10b. County with the Maryland notified at Director 10c. City, Town or Location 10d. Inside City Limits 1 x Yes 2 No DC Washington 10e, Street and Number ò 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be Funeral 1539 29th Street NW 20007 USA filed within 72 hours after death 12. Was Decedent Ever in U.S. UKI 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces?

11 Yes 2 \(\subseteq \) No 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ANo Specify: Specify: Completed 3 Divorced 4 Divorced white the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) President Cellular Communication other Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Henry Walker Bagley Nancy Susan Reynolds 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip C 1539 29th Street NW, Washington, DC 20007 Elizabeth Frawley Bagley/wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State National Crematory 1-072010 4 ☐ Donation 5 ☐ Other (Specify) Falls Church, VA 22. Name and Address of Facility Joseph GAwler's Sons, INC Signature of Funeral Service Licensee 5130 Wisconsin Ave, N.W. Washington DC 20016 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) <u>Ischemic Stroke</u> Medical Examiner Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Ischemic Stroke Records, 1 ☐ Yes 2 ☐ No 3 🛣 Probably 4 ☐ Unknown Hypertension 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page performed? Yes 2 No 1 Yes 2 X No Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 Certificate: To 1 M Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of D ath 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural Accident 5 Pending injury 1 Yes 2 No Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Letical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check riting Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one Signat icense numbe f death (Item 23a) (Type, Print) Registrar's Sign

Registrar

S.copm

SMITH

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	nd 2 strith an 27 is r trau		HAZEL HARRIS / DAUGHTER		Mailing Address (Street 11 SINGER F			-	(ip Code)
- S o) ö°===		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ Removal from State	20b. Place of D	isposition (Name of crematory or other place	Date	·	c. Location - City or	Town, State
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	permit. Departr Importa any Inju		21. Signature of Puneral Service Licensee	Maria	LASA SCO	TT FUNERAL S STREET,	HOME,	P.A.	√D 21079
\mathcal{I}			23a. Part 1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each	ed the death. Do no	t enter the mode of dyir	ng, such as cardiac or r	espiratory arres	it,	Approximate Interval Between
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B	death ne atter ed for u	by Physician/Medical	in the past 12 months? 1 \[\text{\tinct{\tex{\tex	2 Fetal death at time of death	3 ☐ Ectopic pregnanc 5 ☐ Other (specify) _	y		23d. Date of deli Month	Day Year
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OKS, Vital	rsician s certif lirector	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpat	iont 2 🗆 ER/Outn	atient 3 DOA Other	26. Place of Death (C			
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Div	al or A s after I Directed in by	Certification: To	4 Homicide determined 200. Place of III building, e	ic. (Specify)	, street, factory, office	281	City or Town,	et and Number or Ru State)	iral Route Number,
	To the Hospital or Attending Physician: The law requivithin 24 hours after death. To the Funeral Director: After this certificate has been completely filled in by the funeral director, page 2 should	Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the best 2 Medical Examiner: On the basis and manner s	of examination and/o	death occurred at the tir or investigation, in my o	ne, date and place, and pinion, death occurred	d due to the cau at the time, date	ise(s) and manner as e and place, and due	s stated. to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier		29c. License	number	29d	. Date signed (Month	n, Day, Year)
	,		> 8000 MO		D00	65421	Jo	invary 9,	2010
_	LA		30. Name and address of person who completed cause of Christa Fisher, 500 Up	death (Item 23a) (Ty	loa seake	Drive, Bel	Aigv	NO 2101	4
	Sta Registr		31. Date filed (Month, Day, Year) JAN 1 2 2010 32. Regist	rar's Signature	w				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Januare Physician/ 0228 M 200 arie Medical 4a. Facility Name in not institution 4b. City, Town, or Location of Death Examiner 4c. County of Death Meno/. J aston 79/601 If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🔭 F Months Hours Yrs. Director 5 04 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give 2 Maryland 21215-0036 1 Yes 2 No Specify: Specify. Black 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) land Be 17. Father's Name (First, Middle, Last) 18. Mether's Name (First, Middle, Maiden Surname) ည nes ami or Rural Route Number, City or Town, State, Zip Code 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number 10 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other placel Burial 2 Cremation 3 Removal from State 2010 Denton, 4 ☐ Donation 5 ☐ Other (Specify) Easton, MD 2/6/3 21. Signature of Funeral Service Licensee Bennie ast Dover 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner bete Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last The law requires that the death certificate be executed Due to (or as a Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Month Year Pregnant at time of death signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 known Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy performed? Yes 2 A No within 24 hours after death.

To the Funeral Director; After this certificate 1 Yes 2 No Hospital or Attending Physician: completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: Certificate: To 1 N Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 1 Ratural 28c. Injury at work? 28d. Describe how injury occurred injury 5 Pending Investigation 1 Yes 2 No Accident 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 3 and address of person who completed cause of death (Item 23a) (Type, Print) 0

Registrar
DHMH 17 Rev 7/2009

State

31. Date fled (Month, Day, Year)

1 - For State Registrar

Physician

/Medical

Examiner

Funeral

1. Decedent's Name (First, Middle, Last)

5. Social Security Number

088-30-8074

Usual Residence of Decedent

Monique Colsenet Braude

6. Sex

1 □ M 2 💢 F

4a. Facility Name (If not institution, give street and number)

Renaissance Gardens

aryland show	'n	10a. State MD	10b. County Montgome	erv		own or Loca ver Si						10d. Inside City Limits 1 □Yes 2 X No
the M	Funeral Director	10e. Street and Nur	nber				10f. Zip Coo			10g.	Citizen of What Co	puntry?
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items	-nne	11. Marital Status	ed 2□ Married	12. Was Decedent Armed Forces? 1 Tyes 2 Ty		13. W	as Decedent Yes, specify (of Hispanic O Cuban, Mexica	rigin? (Specify Y ın, Puerto Rican	es or No- etc.)	14. Race - Ame Black, Whit	
ours aff "al", or Exami	þ	3 XWidowed	_	If Yes, Give Year or Dates:	•0	1	□Yes 2 🙀	No Specify	<i>r</i> :		Specify: Wh	nite
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uld be filed Aental Hy rked othe tic event,	To Be C	17. Father's Name ((First, Middle, Last d Colsene						ner's Name <i>(Firs</i> Paule Al		en Surname) ne Watie:	:
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinating to mat be multipled at once.				Removal from State	cem	etery, crema	tion (Name of story or other of the	place)	Jan. 7 2010		Location - City or	
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Physician		23a. Part 1. Enter the shock, or hea Immediate Cause of disease or condition	rt failure. List only (Final	one cause on each line Sepsi:	ne.	Do not ente	the mode of	dying, such a	s cardiac or resp	iratory arrest,		Approximate Interval Between Onset and Death 1 Day
/Medical Examiner		resulting in death)		Due to (or as Osteon			ft Foo	t				4 weeks
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ate be exe hysician a	lical Ex	resulting in death) l	Last	Due to (or as	a consequer	nce of):						
an: The law requires that the death certificate be executed tificate has been signed by the attending physician and for, page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was deceden in the past 12 1 □ Yes 2 □ 9 □ Unknown	months? ☐No	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal de	eath 3 🗆	Ectopic pregr Other (specif				23d. Date of de Month	livery Day Year
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ie law requ has been ge 2 shouli	Completed									4a. Was an autopsy performed	prior to death?	utopsy findings available completion of cause of
an: Th tificate tor, pag	a)	25. Was case refer	red to medical					26. Plac	ce of Death (Che	□Yes 2	No 1 □Ye	s 2.☑No
nysicl	To B	examiner? 1 ☐ Yes 2 ☑	No	Hospital: 1 Inpation	ent 2 EF	R/Outpatient	3 □ DOA	Other: 44	Nursing Home	5 ☐ Residence	e 6 □Other (Sp	ecify)
ath. rr: After the	ation:	27. Manner of Deat 1 Natural 2 Accident	5 ☐ Pending investigatio		y, Year) 28	8b. Time of Injury		Injury at Work? 1 ∐Yes 2 □		Describe how in	njury occurred	
To the Hospital or Attending Physicial within 24 hours after death. To the Funeral Director: After this cert completely filled in by the funeral direct	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	i 28e. Place of ini	ury - At home c. <i>(Specify)</i>	e, farm, stre	et, factory, off	ice	28f. L	ocation (Stree ity or Town, S	l and Number or F late)	tural Route Number,
he Hospit n 24 hour he Funera pletely fill	Medical	29a. Certifier (Check only one)		hysician: To the best miner: On the basis of and manner st	of examinatio							
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Sta Registr		31. Date filed (Mon	JAN 06		rar's Signatur	A 1	back	,	V = 7			
HMH 17 Rev 1/2				y		r. 19			<u>.</u>			
						ORIG	INAL					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Months

7. Age (In yrs. last birthday) 84 Yrs.

4b. City, Town, or Location of Death

If Under 1 Year | If Under 24 Hrs.

Days

Silver Spring

Reg. No.

02,

2010

Montgomery

France

4c. County of Death

9:04

9. Birthplace (State or Foreign

10d. Inside City Limits

2. Date of Death
Month
Jan.

8. Date of Birth (Month, Day, Year) Nov. 13, 1925

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Norma Audrey Beall Month 20[°]1°0 Ρм January 09:40 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Anne Arundel 570 Bellerive Road, Apt. Annapolis 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth Funeral 1 □ M 2 😾 F Days Hours Min Month, Pay, Year, 8/15/1931 Maryland Director 220-26-4847 Usual Residence of Decedent works Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
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1 Yes 2 X No þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates, 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 X Widowed 4 □ Divorced 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bessie Prieby James Albert King 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charlotte E. Pantazes/Daughter 1675 Middleneck Rd., Warwick, MD 21912 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot
once, Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Cemetery 1/8/10 Brentwood, MD 21. Signat of Funer State Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Road, Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician ANCER disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or linjury Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ANEMIA, DIABETES, HEART 1 ☐ Yes 2 📶 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of autopsy death? performed? 1 ☐ Yes 2 🔀 No After this certificate 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 NResidence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, Medical 29a. Certifier 🖪 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year) Vellan a Dark of m D24768 January 4, 2010

Registrar
DHMH 17 Rev 7/2009

William A. Dabbs, Jr., 277 Peninsula Farm Road, Arnold, Maryland 21012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

31. Date filed (Month, Day, Year)

JAN 06

			For State Registrar	State of	Maryland		artment of H <i>rtificate of L</i>		d Mental Hy	giene Reg. No. 20	0 01455
	Physicia		1. Decedent's Name (First, Middle Warner S		ıtt				2. Date of De Month Jan 4	Day Ye	3. Time of Death
	/Medic Examin	er	4a. Facility Name (If not institution Carroll Hosp	n, give street and numb	House		4b. City, Town, or Westm	Location of De inster	eath	4c. County of I	Death
ı	Funeral Director		5. Social Security Number 223–38–1548	6. Sex 1 🕱 M 2 🗆 F	Age (In yrs. la 78	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours M	in. 8. Date of Bi (Month, D Aug.	ay, Year)	Birthplace (State or Foreign Country) ashington,D.C.
ryland	show	_	Usual Residence of Decedent 10a. State 10b. County Md • Car	roll	1	Town or Lo	cation inster			-	10d. Inside City Limits 1 □Yes 2 ▼No
th the Me	or 28a-f	Directo	10e. Street and Number		-	WCS CIII.	10f. Zip Code	01150		10g. Citizen of Wha	t Country?
death w	ems 23a er must b	Funeral Director	1000 Weller Ci	rcle #316	ent Ever in U.S	. 13. \	Nas Decedent of Hi f Yes, specify Cuba	21158 spanic Origin? n, Mexican, Pu	(Specify Yes or Nerto Rican, etc.)		d States American Indian, White, etc.
olire affer	ral", or it	þ	1 ☐ Never Married 2 ☑ Marri 3 ☐ Widowed 4 ☐ Divorced	ried 1 XYes 2	□ No 193	0-	I □Yes 2 No	Specify:		Specify:	White
of should be filed within 72 hours after death with the Maryland	Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ite Medical Examiner must be notified at once.	Completed	(Specify only highe Elementary/Secondary (0-12)	t's Education st grade completed) College (1-4	or 5+)	(Give life. L	dent's Usual Occupa kind of work done of DO NOT use retired	luring most of v	vorking	16b. Kind of Busin	ess/Industry
ا المالة عد	tal Hygie d other t	Be Co	12 17. Father's Name (First, Middle,	Last)		_	Printer			e, Maiden Surname)	icing
y la	marker marker matic	ဥ	Jesse Butt 19a. Informant's Name/Relations	ship (Type, Print)		19b. Mailir	na Address (Street a	Guss and Number or		ter ber, City or Town, Sta	ate, Zip Code)
and 2 e	auth ar n 27 is er trau		Shirley A. But			1000	Weller C	ircle,	#316, We	stminster	, Md. 21158
Pages 1	nent of He int: If iten iry or oth		20a. Method of Disposition 1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (S		ate i		sition (Name of natory or other place ille Cem.		Date 77/2010	20c. Location - Cit	y or Town, State
The state of	Departr Imports any inju		21. Signature of Funeral Service	Licensee . Soule	`	22	Name and Addres Muriel H. P. O. Bo	ss of Facility Barber x 5038.	Funeral	Home	. 20882
			23a. Part 1. Enter the disease, or shock, or heart ailure. List Immediate Cause (Final	complications that cau only one cause on eac	sed the death.				-		Approximate Interval Between Onset and Death
1	hysician /Medical xaminer		disease or condition resulting in death)	Due to (or	as a conseque	ence of):					
pe	sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b Due to (or	as a conseque	ence of):					
be execut	sician and burial-transit	dical Examiner	that initiated events resulting in death) Last	CDue to (or	as a conseque	ence of):					
rificate	ng physi as the t	Medic	IF FEMALE:	a							
The law requires that the death certificate be executed	by the attending parached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		th 2 Tetal nt at time of de	death 3	Ectopic pregnancy Other (specify)	<i>y</i>		23d. Date o Month	· ·
uires that t	signed by	þ	Part II. Other significant conditi	ons contributing to dea	th but not resul	lting in the u	nderlying cause give	en in Part I.			ite to the cause of death?
e law red	e has been s ge 2 should	Completed								s an 24b. We priormed?	
ian: T	r this certificate ha	Be Co	25. Was case referred to medica examiner?	1				26. Place of I	1 ☐ Yes Death <i>(Check</i> o <i>nly</i>		Yes 2 No
Physic	r this or	မ	1 Yes 2 No 27. Manner of Death	28a. Date of	oatient 2 E	ER/Outpatier 28b. Time o		4 🗆 Nursin		sidence 6 Other	(Specify)
Hospital or Attending Physician:	death. ctor: After y the funer	Certification:	3 Suicide 6 Could	gation not be	Day, Year)	Injury me, farm, str		c? Yes 2 □ No	28f. Location	(Street and Number	or Rural Route Number,
ital or /	rs after ral Dire		4 Hornicide	building	, etc. (Specify,					own, State)	
he Hosp	within 24 hours after death. To the Funeral Director: A completely filled in by the to	Medical		ng Physician: To the base Examiner: On the base and manner	sis of examinati						
To the	with To t	N	29b. Signature and title of certified	to Kuler			29c. Licens	s number $\frac{1}{5}$	₹.	29d. Pate signed (I	Month, Day, Year)
12	+1		30. Name and address of person Flavio Kruter	who completed cause	of death (Item)Ostmi	uster (H)	N 21157	
	Sta Registr		31. Date filed (Month, Day, Year,		gistrar's Signati	ure	parker				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		•	1 - State Registrar				Cer	tificate	e of D	eath			Reg. No	20	110	UII	420
	Physicia	n/	1. Decedent's Name (First, Middle	, Last)								2. Date of De	ath Da	ıv	Year	3. Time of	Death
	Medic		KENNE		RDON	BAR	NHOUS					Janua:			10	5:40	AM
-	Examin	er	4a. Facility Name (if not institution,					4b. City,	Town, or	Location	of Death		4c		y of Death		
	_		Frederick Men						ederi		Ò4 II			Fre	deric		
	Funeral Director		5. Social Security Number 212-50-8173	6. Sex 1 M 2 D	F 7. Age	e (In yrs. last i	birthday) Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of Bir (Month, Da June 2	th ay, Yea <i>r)</i> 2 , 19	47	9. Birthp Coun Mary	lace (State o ry) and	r Foreign
7	L ow		Usual Residence of Decedent 10a. State 10b. County			10c. City, To	our or loa	otion							1	0d. Inside Ci	by Limite
V Pur	-fsh edar	먕				TOG. City, it			1 ole						- 1'	1 X Yes	
Mar	28a notifi	ire		derick			В	unsw									2 L INO
with the	s 23a or	Funeral Director	10e. Street and Number 202 Tama1	rack Way	,			10f. Zip		21716	5		0		What Cour		
d+col	item er m		11. Marital Status	12. Was D	ecedent E Forces?	ver in U.S.	13. V	Vas Deced	ent of His	panic Ori	igin? (Spe	cify Yes or No- Rican, etc.)			ce - Americ		
	ral", or Examin	Completed by	1 ☐ Never Married 2 😿 Marr 3 ☐ Widowed 4 ☐ Divorced	ried 1 💢 Y If Yes,	'es 2 🗌	№ 1966 1970	5- 1	☐ Yes				i ilicani, cic.,		Specify			
	natu	Set	15. Deceder (Specify only highe	nt's Education	ted)	-	16a. Deced	ent's Usua			t of work	na	16b. k	(ind of E	Business Inc	lustry	
ithin 70	r than "		Elementary/Seconday (0-12)		e (1-4 or 5	i+)	Ìife. DC	NOT use perat	retired)	inig mos	it of work	ng		Ma	anufa	ctorin	g
	ental Hyg rked othe ic event,	To Be	17. Father's Name (First, Middle, L Harry E. Ba			•						(First, Middle Garrot		Surnam	ne)		
V IDIVI	alth and M		19a. Informant's Name/Relationsh Patricia Barnh		Wife		19b. Mailin 202	g Address Yama ı	(Street a	nd Numb Way,	er or Rura Bru	Route Numbers	er, City or MD	217	State, Zip $^{\circ}$	Code)	
	perfilt. Tage I am 2. should be there within 2. hous after death with the way and perfilt. Tage I am 2. should be the Martal Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		rom State	cem	e of Dispos etery, crem ffer	natory or o	ther place		L/8/2	Date 1010			- City or To	wn, State	
i i	Departn Imports any inju		21. Signate of Funeral Service L	Stau	Hon	· _	22	. Name an	d Addres	s of Facili	Ave.	, Stau	ffer. swic	Fur k, y	eral D 217	Home 16	
			23a. Rart 1. Enter the disease, or shock, or heart failure. List of	complications t	at caused	the death. D	Do not ente	r the mod	e of dying	, such as	cardiac o	or respiratory a	rrest,		23.0	Approximat Interval Bet	
P	nysician/ Medical		Immediate Cause (Final disease or condition resulting in death)	_ a. S∈	PSI.	S										Onset and I	Death
	Examiner	_	Sequentially list conditions,	b. Ru		a consequent	ABZ	omi	NAL	. Ve	scu	2					
ted.	insit	Examiner	it any, leading to immediate cause. Enter Underlying Cause (Disease or linjury	Due	to (or as	a consequeri	ce oij.										
tificate be executed	physician and the burial-transit	sal Ex	that initiated events resulting in death) Last	Due	to (or as	a consequen	ce of):										
3 4	phys the l	Medical		d													
Division of Attending Physician. The law requires that the death certific	the attending plant for use as t	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1	ive Birth	of pregnancy 2 Fetal de at time of dea	eath 3	Ectopic Other (sp		/					ate of delive onth		/ear
es that th	signed by the a		Part II. Other significant condition		to death b	out not resulti	ing in the u	nderlying	ause giv	en in Part	l.					e cause of d	
	been signe should be	etec			,											osy findings a	
De law r	ate has b	Completed by										24a. Was auto perf 1 \(\sum \) Yes	psy ormed?			mpletion of c	
	certificate ector, pag	Be	25. Was case referred to medical examiner?	1					26. Pla	ce of Dea	ath (Chec	k only one)					
weic	this certific ral director,	2	1 Yes 2 No	Hospital:	□ Inpati	ent 2 🗷 ER	R/Outpatien	t 3 🗆 🗅	Othe DA	r: 4 □ N	ursing Ho	me 5 🗆 Res	idence (6 🗆 Oth	ner (Specify)	
oding p	ath. 7 After the funeral		27. Manner of Death 1 Natural 5 □ Pendir 2 □ Accident Investi	ng (/	ate of inju Month, Dag	iry 28 y, Year)	Bb. Time of injury	M 2	8c. Injury work		_	28d. Describe	how injur	y occur	red		
	within 24 hours after death. To the Funeral Director, A completed filled in by the fu	l Certificate;	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	28e. P		ury - At home c. (Specify)	e, farm, stre	eet, factor	, office			28f. Location (City or To			oer or Rural	Route Numb	er,
Hospi	n 24 hou ne Funer	Medical	(Check 2 Medical E	g Physician: To t Examiner: On the g Nurse Praction	basis of e	xamination ar	nd/or invest	igation, in	my opinio	n, death o	ccurred a	the time, date	and place	e, and du	ue to the car	use(s) and ma	nner stated.
, L	Within Volume Comp.	_	29b. Signature and title of certifier	ripe M	0			290	License		4			/	ed (Month, i	Day, Year)	
12	+1		30. Name and address of person	who completed		leath (Item 23		Print)	Fo	ときつき	- R 11	K MI) 2	170			-
10	Sta		31. Date filed (Month, Day, Year)		2. Registr	's Signature		ba	Red			16			*		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Car1 Edwin Brunner anvar. 010 9:00 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital Hagerstown Washington Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Feb. 2, Year 1924 1 **X** M 2 □ F Hours Months Pennsylvania Director 219-14-8699 Yrs. Usual Residence of Decedent show 10a. State 10c. City, Town or Location must be notified at 10d. Inside City Limits Director 28a-f 1 🗌 Yes 2 ី No MD Washington Hagerstown 10e, Street and Numbe ŏ 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 17930 Pin Oak Road 21740 U.S.A. items (12 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 27 is marked other than "natural", or itel traumatic event, the Medical Examiner Armed Forces? Black, White, etc. ģ 1 Never Married 2 XMarried Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White 3 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) 5+ Education <u>Teacher</u> permit. Page 1 and 2 should be filed Department of Health and Mental Hyg Important; if item 27 is marked other any injury or other traumastics. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Clayton E. Brunner Agnes J. Olsen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21742 20325 Youngstoun Ct., Hagerstown, MD Carl E. Brunner/Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 ☐ Burial 2 🕅 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 1/13/2010 Smithsburg, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave., Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Interval Between Onset and Death Immediate Cause (Final rsease Physician/ disease or condition Medical resulting in death) Due to lor as a consequence of) Examiner Sequentially list conditions Examine Due to for as a consequence on If any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last -tran Due to (or as a consequence of): physician s the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 4 Pregnant at time of death 9 Unknown Day Year ed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autonsy 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည 2 🗌 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at ospital or Attending P 1 hours after death.

'uneral Director: After' ied filled in by the funer 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 24 hours Medical Tertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2 To the F Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D58853 209

State Registrar

5H 3+1

Box 68760

Division of Vital

DHMH 17 Rev 7/2009

HABIB

31. Date filed (Month, Day, Year)

Street, Hogerstown, MD 21740

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHOTANI 251 E Antietam

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Menth AN **Physician** 6:52 AM ENNIE 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard Howard County General Hospital Columbia If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 01/14/1933 9. Birthplace (State or Foreign **Funeral** Months Days Hours Michigan Director 76 380-30-7463 Usual Residence of Decedent 10a. State 10c, City. Town or Location 10d. Inside City Limits 10b. County **Funeral Director** 1 ☐ Yes 2 X No Silver Spring Maruland Montaomeru 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 710 Lamberton Drive 20902 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ሺ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 1 Never Married 2 Married If Yes, Give Year or Dates: 1 Tyes 2 No. Specify þ 3 X Widowed 4 ☐ Divorced Caucasian Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Henry Davis မ Florence Mary (Unknown) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Clesner - Son 10425 Huntley Avenue, Silver Spring, Maryland 20902 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Judean Memorial Grds | 01/05/2010 | Olney, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the dise se, shock, or heart failure. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** brovascu /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by nneunconi 1 Yes 2 No 3 Probably 4 Vinknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No 24a. Was an 2 XNo 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Date of Injury (Month, Day, Year) Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 No 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division of Vital Records, P.O. Box 68760, reral Director: , filled in by the f

State Registrar

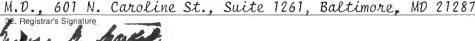
Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Kim Lesley Goring, 31. Date filed (Month, Day, Year) JAN 07 2010



and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Under the date and place, and due to the cause(s) and manner as stated. Described the date and place, and due to the cause(s) and manner as stated.

6

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - State of Maryland / Department of Health and Mental Hygiene 2 0 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Steven CHIAVERINI Physician/ January 6^{ay} , 201 0^{ear} 7:20 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Bethesda Montgomery 7009 Rainswood Court Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours March Day Year) 1957 Pennsylvania Yrs **Director** 52 <u> 193-38**-**3167</u> Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Bethesda Maryland Montgomery 1 ☐ Yes 2 🗶 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 20817 7005 Rainswood Court Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. white 1 Never Married 2 Married 1 ☐ Yes 2 ☒No If Yes, Give Year or Dates. "natural", or þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72 hand Mental Hygiene.
7 is marked other than "n (Give kind of work done during most of working life. DO NOT use retired) Hospital and Elementary/Seconday (0-12) College (1-4 or 5+) Eldercare Management Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Savreyk မ Helen Catherine Saury Vincent Chiaverini 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zip Code) 7005 Rainswood Court, Bethesda, MD 20817 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is any injury or other tra Joan Wolf, Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Mt. Lebanon Cemetery 01/08/10 Adelphi, MD 4 ☐ Donation 5 ☐ Other (Specify) Torchings year few Funeral Home NW. Washington, DC 20012 Carroll St. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and De Immediate Cause (Final Physician/ disease or condition resulting in death) Ourous mos Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) The law requires that the death certificate be executed burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician I for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3

Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) Year Dav Pregnant at time of death 1 ☐ Yes ∠ ☐ 9 ☐ Unknown been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? performed Yes 2 No 2 No 1 🗌 Yes vithin 24 hours after death.

o the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical or Attending Physician: Be 26. Place of Death (Check only one) examiner? 1 XYes 61349012 Other: 2 🗌 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Unk ☐ Natural ☐ Accident 5 Pending self inflicted co P01500 1 Yes 2 No Investigation 6 Could not be Jan 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) determined Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check To the within 2 only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 000458 er mo omE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2101 and Park BRECHER mo DonE Gilver 31. Date filed (Month, Day Year) State Registrar

DHMH 17 Rev 7/2009

Box 68760

P.O.

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 6, 2010 January Phi An Cao /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince Regional Hospital George' _aure| -dure If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 1 X M 2 □ F 24 Maryland 11/12/1985 Director 215-21-2531 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County יי יי ייים מזור than "natural", or items 23a or 28a-f show traumatic event, ולא Modical Examitar must be notified at 1 ☐Yes 2 V No Director Beltsville Maryland Prince George's 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with 20705 U.S.A. 4722 Brandon Lane Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status filed within 72 hours after 1 ☐Yes 2 No 1 ☐ Never Married 2 X Married If Yes, Give Year or Dates: 1 □Yes 2 🛣 No Specify Specify. þ 3 Widowed 4 Divorced Asian Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, it a Maric once. College (1-4or 5+) Elementary/Secondary (0-12) Heat Treat Technician Aerospace 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nhieu Thi Pham Tin An Cao ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4722 Brandon Lane. Beltsville. Maryland 20705 Nhieu Thi Pham - Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 🗓 Burial 2 ☐ Cremation 3 ☐ Removal from State | 01/11/2010 | Silver Spring, MD Gate of Heaven Cem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. OTO HOH 21. Signature of Funeral Service Licensee 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart fature. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Final disease or condition resulting in death) Physician Gy (/Medical Due to (or as a consequence of): Examiner Due to (or see a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner e Hospital or Attending Physician: The law requires that the death certificate be executed 124 hours after death.

• Puneral Director: After this certificate has been signed by the attending physician and letely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 □ Yes 2 □ No Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ≥ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 X No 1 □ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check on npletely

State Registrar 29b. Signature and title of certifier

027 31. Date filed (Month, Day, Year)

To the I

Baltimore, Maryland 21215-0036

Box 68760,

Division of Vital Records, P.O.

aurel Regional Hospital

License number

0067210

7300

29d. Date signed (Month, Day, Year)

Van Dusen Road

20707

10

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1cn 11

08 2010

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Ar	nend I	te	em: 9 & 17 Please Type of Print in Black indelible in		-	_	
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			Registrar 1/14/2010 rjw Certificate of	I Dealli	2. Date of Death	J. No. C 0 1 0	3. Time of Death
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in the same	/Medic		Gail Faith Curlott 4a. Facility Name (If not institution, give street and number) 4b. City, Town,	n, or Location of Death	January	10 2010 4c. County of Death	03:46 AM
nel.	, Examin	er	Union Hospital of Cecil County Elkt			Cecil	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Yea	ar If Under 24 Hrs.	8. Date of Birth (Month, Day,		laced State or Foreign
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	and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				isville Od. Inside City Limits
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	r 28a notif	Director	Maryland Cecil North East 10e. Street and Number 10f. Zip Code	e	100	g. Citizen of What Cour	itry?
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yla	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the Ta	ို	distribution at century				
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylar of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the "red call Exminer must be notified at		19a. Informant's Name/Relationship (Type. Print) Heather Campbell / Daughter 19b. Mailing Address (Street Properties) 179 Red Point	et and Number or Rura	al Route Number, (City or Town, State, Zip	Code)
	permit. Pages 1 and 2 Department of Health Important: If item 27 I any injury or other tra once.	-			Date 20	oc. Location - City or To	
altimore,	permit. Pages 1 Department of H Important: If ite any injury or ot once.		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	;	ary 12,		
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	ospita hours inera ly fille		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the (Check only Medical Examiner: On the basis of examination and/or investigation, in m				
	the Ho in 24 the Fu	edical	one) and manner stated.		red at the time, dat	te and place, and due to	the cause(s)
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	_		1 Cheysour DC	JUUU T.	20	1 11120	
	5		30. Name and address of per on whi completed cause of death (Item 23a) (Type, Print)	3 wm	oin St	Elklo	MILL
	Sta	te	31. Date filed (Month, Day, Year) 82, Registrar's Signature) ,
	Registr		JAN 12 2010 6 1 1 1 1 1000				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Year MARCIA JANUARY 072010 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death HESTER RIVER HOSPITAL 8. Date of Birth (Month, Day, Nov. 9, If Under 1 Year Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Colorado 1 ☐ M 2 ☐ vF 096-22-9583 85 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location or 28a-f show 10d. Inside City Limits ral", or Items 23a or 28a-f s Examinar must be notified Director 1 Yes 2 No Maryland Kent Chestertown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 463 Heron Point 21620 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0036 þ If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No 3 ☐ Widowed 4 ☐ Divorced White Completed the Midden 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) other than Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ith and Ment 27 Is marked traumetice Henning Oriole Taube Ida Josephine Campbell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Depertment of Health Importent: If item 27 eny Injury or other trong. Donald Demarest/Husband 463 Heron Point Chestertown, MD 21620 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🗡 Cremation 3 ☐ Removal from State Chesapeake Cremation Cntr. 1/11/10 Stevensville, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Euneral Service Licenses Fellows, Helfenbein & Newnam Funeral Home 130 Speer Rd. Chestertown, MD 21620 23a. Part 1. Enter the disease, or compositions a caused the shock, or heart failure. List only one cause on each line caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed sicien and burial-trans Due to (or as a consequence of): physicien s the burial Box 68760 Physician/Medical attending pl IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month 5 ☐ Other (specify) P.O. I 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ۵ 2 No 1 🗌 Yes 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe After this certificate Division of Vital 1 ☐ Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signa 00060301 0 Name and address of person pleted c m 5 31. Date filed (Month, Day, Year) State barke Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death January Physician/ 20 Î O 7:01 A Haze1 W. Davis Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Adelphi Nursing Home Hillhaven If Under 1 Year | If Under 24 Hrs. 8. Date of Birth | Months | Days | Hours | Min. | Oct. 23, 1913 7. Age (In yrs. last birthday) 96 yrs. Social Security Number 9. Birthplace (State or Foreign Funeral 1 🗆 M 2 🕱 F Virginia 212-50-9816 Director Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State ral", or items 23a or 28a-f sho Examiner must be notified at Director Hyattsville 1 Tx Yes 2 □ No Montgomery Maryland| 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20782 United States 4916-18 LaSalle Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces No Black, White, etc. þ 1 Never Married 2 Married ier than "natural", ເ , the Medical Exam 1 ☐ Yes 2X No Specify: Specify: White If Yes, Give Year or Dates 3 Nidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry d 2 should be filed within 72 all alth and Mental Hygiene.
27 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker traumatic event, 18. Mother's Name (First, Middle, Maiden Surname)
Daisy Hoffman Be 17. Father's Name (First, Middle, Last) ೭ Richard Wilson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5009 Hollywood Rd., College Park, MD 20740 1 and 2 s of Health item 27 i Blaine Davis / Son 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of permit, Page 1 a
Department of IImportant: If ite
any injury or ott cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Hillsboro, Virginia 1/8/2010 Hillsboro Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Stauffer Funeral Home, 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1100 North Maple Ave., Brunswick, MD 21716 23a. L. Enter the distate, or complications that used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failur. List only one cause on each line. Approximate Interval Between Onset and Death Min. Immediate Cause (Final Cardiac Arrythmia Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner 30 Yrs. Cornary Artery Disease Sequentially fist conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): attending physician and for use as the burial-transit 40 Yrs. <u>Hyperlipidemia</u> that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Year Month Day Pregnant at time of death cate has been signed by the a page 2 should be detached to 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown Electrolyte Abnormality 24b. Were autopsy findings available prior to completion of cause of death? Dementia, Masculae Degeneration 24a. Was an autopsy performed 1 🗌 Yes 2 🔲 No certificate Yes 2 No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certificated filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 Ho Other: 4 PNursing Home 5 ☐ Residence 6 ☐ Other (Specify) ၉ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) . Manner of Death Natural 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year) 1/5/2010 29b. Signature an title of certifier 29c. License number D17843 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Vivek C. Vivek, MD 3311 Toledo Terrace, Hyattsville, MD 20782

State

Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2010 Year William Dembrow January 7:10 a M Daniel Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 12509 Two Farm Drive Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) May 25, 1920 044-18-8390 1 XM 2 F 89 Ohio Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mential Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified 1 ☐ Yes 2 🏝 No Silver Spring Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number "natural", or items 23a or dical Examiner must be Funeral 20904 USA 12509 Two Farm Drive 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. ģ 1 Never Married 2 👿 Married 1 ☐ Yes If Yes, Give 2 **X** No Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced Completed Year or Dates and Mental Hygiene.
is marked other than "naturaumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) 5+ Engineer Aeronautic/Space Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Lillian Sarah Cohen William Louis Dembrow 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12509 Two Farm Drive, Silver Spring, MD 20904 Catherine Louise Dembrow/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date injury or Gate of Heaven Cemetery Silver Spring, Maryland 22 Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd. W., Silver Spring, 21. Signature of Funeral Service Licensee MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Prostate Cancer disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner End-Stage Alzheimer's Dementia Sequentially list conditions, if any, heding to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of Hospital or Atteriding Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death signed by the and be detached for Yes 9 Unknown 1 ☐ Yes 2 L 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗆 Yes 2 😾 No 3 🗆 Probably 4 🗀 Unknown Completed Hypertension certificate has been si rector, page 2 should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2**X** No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 5 \square Pending 1 🛣 Natural death. ☐ Accident ☐ Suicide Investigation a er death Director 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 10 5219 Richefield Rd. Bethe sda Gatti 31. Date filed (Month, Day, Year JAN 08 20

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 7:10 Michael Everett Dale 6man Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Baltimore Washington Medical Center Glen Burnie If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number Age (In yrs, last birthday) **Funeral** Days Hours Min. July 19, 1938 579-46-8177 1 🙀 M 2 🗆 F 71 Washington, DC Director Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State with the Maryland Director 1 ☐ Yes ŽX No Maryland Anne Arundel Chester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7016 Bridgepointe Drive 21619 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ★Yes 2 No If Yes, Give Year or Dates. 1 1 Never Married 2 Married Completed by e. Maryland 21215-0036 1 🗌 Yes 2 🔀 No Specify. Specify: 3 x Widowed 4 ☐ Divorced 1955-57 White 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Plumber Plumbing nd Mental Hygier marked other t Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Wilmer Everett Dale Mary Audrey George permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7016 Bridgepointe Drive, Chester, MD 21619 Donna Marie Khiel/Daughter 20c. Location - City or Town, State 20a Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place)
Gate of Heaven Cemetery Jan. 8, 1 🗷 Burial 2 🗌 Cremation 3 🗋 Removal from State Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21, Signature of Funeral Service Licenses Name and Address of Facility ancis J. Collins Funeral Home 22 Name and Acores Ollins' Funeral Home Inc. Francis J. Collins' Funeral Home Inc. 500 University Blvd. W., Silver Spring, Md 20901 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): the Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Ectopic pregnancy Month Dav 5 Other (specify) Pregnant at time of death is certificate has been signed by the director, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗌 No 1 Yes Yes 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 2 IN No မ 1 Mnpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, After this 28c. Injury at work?
1 Yes 2 No Certificate: 27. Manner of Death 28a. Date of injury 28b. Time of 28d. Describe how injury occurred (Month, Day, Year) Natural Accident 5 Pending after death Director: A d in by the f Investigation Suicide
Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State within 24 hours aff

To the Funeral Di

completed filled in Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. з 🗍 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number è + s of person who completed cause 23a) (Type, Print)

State Registrar b

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2010 01466 State of Maryland / Department of Health and Mental Hygiene Kevin Demmer 1- For State Certificate of Death Registra 2. Date of Death 3. Time of Death Decedent's Name (First, Middle,Last) Physician/ Month Day January 11, 2010 0022 hrs VIN CRAIG Madical Examiner 4b. City, Town, or Location of Death 4c. County of Death Facility Name (if not institution, give street and numbe Baltimore St. Agnes Hospital If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Min Country) Director M 2 F Usual Residence of Decedent 10d, Inside City Limits 10a. State 10c. City, Town or Location 1 Yes 2 No item 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the <u>Medical Examiner must be notified at once.</u> e, MD 21215-0036 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Director 10e Street and Number Race - American Indian, Black, Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. Funeral If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 2 No Yes If item 27 is marked other than "natural", or SHITE Yes 2 No specify: Specify: If Yes, Give Year Widowed ð 16b. Kind of Business/industry Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Elementary/Secondary (0-12) College (1-4 or 5+) 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) E. DEEMER SR. (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19b. Mailing Address BUIE MD. 2(06) crematory or other place) permit. Pages 1 Department of H 2 Cremation 3 Removal from State important; REMATORY Donation 5 Other Specific 9 Approximate Interval replications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sh Physician Between Onset and /Medical Methadone intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and - transit Physician/Medical X UNPENDED AMENDED attending physician or use as the burial 23a,27,28a-f,perm,E g900 2/18/10 TT death certificate be Box 68760. 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: 23b. Was decedent pregnant in the Day Month Year Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions o ð Yes 2 ✔ No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available certificate has been prior to completion of cause of autopsy performed death? **✓** Yes Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical the Hospital or Attending Physician: hin 24 hours after death. Vital director Be Other₄ Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ✔ DOA Nursing Home 5 Residence 6 Other this 1 🗸 Yes 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) ö 27. Manner of Death 28b. Time of Injury After Certification: 1 Yes 2 No Natura Pending Fd 1/10/10 11:40 Fd рm the Investigation Accident 28f. Location (Street and Number of Rural Route Number, City of Town, State) 2738 Washington Blvd Baltimore, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc. found at residence Could not be Suicide determined Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 1 Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number January 12, 2010 O.C.M.E. person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Victor Weedn MD JD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001 OCMF 2006

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1 - For State Registrar	e of Marylan		artment of H tificate of L			711	10 01467
Physicis	nn/	1. Decedent's Name (First, Middle, Last)			timouto or E	Journ	2. Date of Dea		3. Time of Death
Physicia Medi	cal	James Walter Ford, Jr.	I mumbori				January	4, 2010	4:44 p M
Examir	ier	4a. Facility Name (if not institution, give street and Suburban Hospital	numberj			r Location of Death Bethesda		4c. County o	of Death Intgomery
Funeral Director		5. Social Security Number 6. Sex 199–16–6029 1 🖺 M 2 🗆	7. Age (In yrs. la	ast birthday) 81 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day Sept. 17,	h	9. Birthplace (State or Foreign Country) Pennsylvania
and show at	'n	Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits
Maryle 28a-f	Director	Maryland Montgor	mery	Silver	Spring				1 ☐ Yes 2 🛣 No
s 23a or	Funeral D	10e. Street and Number 15407 Prince Frederick Wa	ay		10f. Zip Code 2 0	906		10g. Citizen of W	hat Country?
Baltimore, Maryland 21215-0036 permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	Arme 1 Never Married 2 Married 1 Arme 1 Windowed 1 Diversed If Yes	Decedent Ever in U.S d Forces? Yes 2 \(\sum \) No i, Give \(1946-in the control of the con	1	Vas Decedent of Hi FYes, specify Cuba	ispanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		- American Indian, , White, etc. White
21215-0036 within 72 hours after giene. rer than "natural", o	Completed	15. Decedent's Education (Specify only highest grade comple Elementary/Seconday (0-12) Collection	eted) ge (1-4 or 5+)	(Give I life. De	O NOT use retired)	during most of work		16b. Kind of Bus	1
d 21 ed with Hygien other th	Be C	17. Father's Name (First, Middle, Last)		Certi	fied Public	18. Mother's Nam		Federal G	overnment
ylan Id be fill Mental arked c	2	James Walter Ford, Sr.				Isabell	,	viaiden Garname)	
, Maryland nd 2 should be filed salth and Mental Hy n 27 is marked oth er traumatic event	di j	19a. Informant's Name/Relationship (Type, Print) Dorothy M. Ford/Wife	, i	19b. Mailin 154 0	g Address (Street a 7 Prince Fr	and Number or Run cederick Wa	al Route Number y, Silver	; City or Town, Sta Spring, MD	ate, Zio Code) 20906
Baltimore, permit. Page 1 and Department of Hea Important: If item any injury or other once.		20a. Method of Disposition 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal 4 ☐ Donation 5 ☐ Other (Specify)	from State 20b. Pi	lace of Dispo emetery, cren opolita	sition (Name of natory or other place n Cremator y	^{;e)} Jan 201	Date • 9,		City or Town, State a, Virginia
Balti permit. Departr Imports any inju	18	21. Si nature / Funeral Service icensee	1	22 F: 5	Name and Addrese rancis J. C 00 Universi	Soffacility Collins Fun- ity Blvd. W	eral Home ., Silver	Inc.	
⊦hysician/ → Medical		23a. Part 1. Enter the disease, or complications t shock, or heart failure. List only one cause of Immediate Cause (Final disease or condition resulting in death)	on each line.		77963		,		Approximate Interval Between Onset and Death
Examiner	ڀ	Sequentially list conditions, b.	e to (or as a consequ	ence of):	retic	Infare heart	disc	ease	10 years
d d	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	e to (or as a consequ						
oe execu ician and burial-tra	sal Ex	that initiated events c. Dur	e to (or as a consequ	ence of):					
8760 ificate be ig physic as the bi	Medical	d			· · · · · ·				
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate be execund within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	in the past 12 months?	, outcome of pregnar Live Birth 2 ☐ Fetal Pregnant at time of d Unknown	death 3	Ectopic pregnanc Other (specify)	у		23d. Date Mont	of delivery th Day Year
es that the signed by	by	Part II. Other significant conditions contributing			/		23e. Did to	١.	oute to the cause of death?
cords	Completed				oci i i i		24a. Was a	in 24b. W	ere autopsy findings available for to completion of cause of
Rec The la icate ha	_							med? de	eath? Yes 2 No
Vital /sician /sician	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:	1 🗆 Inpatient 2 🔀	FR/Outpatien	Oth	er:		ence 6 🗆 Other	(Specific)
Jivision of Vital Recc I or Attending Physician: The law after death. Director: After this certificate has I in by the funeral director, page 2 &		27. Manner of Death 28a. I		28b. Time of injury	28c. Injury work	/ at		ow injury occurred	
Jivisio Il or Atter after dea Director	Certificate:	3 Suicide 6 Could not be 28e. P	lace of Injury - At hor uilding, etc. (Specify)		eet, factory, office		28f. Location (St City or Town		or Rural Route Number,
Hospita 24 hours E Funeral	Medical	29a. Certifier 1 Certifying Physician: To to 2 Medical Examiner: On the only one) 3 Certifying Nurse Praction	e basis of examination	and/or invest	igation, in my opinio	n, death occurred a	t the time, date ar	nd place, and due t	to the cause(s) and manner stated.
To the vithir comp	2	29b. Signature and title of certifier	- I Sub year of the	orriougo, o	29c. License	number	2	29d. Date signed ((Month, Day, Year)
Jot!		30. Name and address of person who completed	Cause of death (Item	23a) (Type P		35/03		1/7/	2010
		Stephen Vaccarezza, MD	6240 Mont	rose Ro	ad, Rockvil	Lle, MD 208	52		
Sta Registra	te ar	31. Date filed (Month, Day, Year) JAN 08 2010	2. Registrar's Signati	bes	4				

4,2010

Jan

JR, James

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Jan. 2016 5:00a M William B. Flick Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1893 Liberty Grove Rd. Colora Ceci1 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 X M 2 - F Min. Hours 83 Yrs. 206-14-2757 PΑ Director Usual Residence of Decedent 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland any injury or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No Ceci1 Colora 10e. Street and Numbe 10f. Zip Code 23a or 10g. Citizen of What Country? Completed by Funeral 21917 1893 Liberty Grove Rd. USA than "natural", or items permit, Page 1 and 2 should be filed within 72 hours after death : Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔯 No Specify. If Yes. Give Specify: White 3 Widowed 4 Divorced 1945-47 Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) 12 Postal Carrier U.S. Postal Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William Flick Anna L. Sheffler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jane M. Flick/ wife 1893 Liberty Grove Rd. Colora, MD 21917 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) R.T. Foard Funeral Home, Rising Sun, MD 21. Signature of Funeral Service Licenses ²² Name and Address of Facility R.I. Foard Funeral Home, P.A 111 S. Queen St. Rising Sun, P.A. uchas fons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest ause on each line. 23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ seas disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to for as a consequence of: the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 5 Other (specify) Pregnant at time of death signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown Completed iis certificate has been si director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 X No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No မ 1 Inpatient 2 I ER/Outpatient 3 I DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of After t 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide determined within 24 hours af

To the Funeral Di

completed filled in Medical Extifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗖 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one and title of certifier 29b. Signatuje 29c. License number 29d. Date

State Registrar 31. Date filed (Month, Day, Year)

30. Marrie and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Jimmie Lewis Fitzgerald 2ัซี่1ก Jan 10 9:57 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Clinton Prince George's Social Security Numbe 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 ₹ M 2 □ F Months Days Hours Min. (Month, Day, Sept] 79 193b Virginia 231 36 0507 Director Usual Residence of Decedent ms 23a or 28a-f shov must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location be filed within 72 hours after death with the Maryland Director 1 ☐ Yes 2 XXNo Maryland Prince George's Upper Marlboro 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 9817 Hammer Lane 20772 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Race - American Indian Examiner Armed Forces?

1 X X Yes 2 \(\text{No.16} \) No. If Yes, Give 1 Q 5 Black, White, etc. 0. Completed by 1 Never Married 2 Married 21215-0036 It Yes, Give 1953-1955 Year or Dates 1 ☐ Yes 2 V No Specify: Black 3 Widowed 4 XXDivorced and Mental Hygiene.
Is marked other than "natur raumatic event, the Medical 16a, Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) USA Federal Government Maintence Worker Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Thomas Fitzgerald Oueen Womack permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any injury or other traumatic. once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elton Fitzgerald (Son) 9817 Hammer Lane, Upper Marlboro, MD 20772 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Cheltenham, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cemetery 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old 21. Signature of Funeral Service Ligensee V70 Alexandria Ferry Road, Clinton, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical Examiner resulting in death) Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to for as a consequence of resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death signed by the a d be detached for q 🗌 Unknown g 🔲 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy certificate 1 Yes 2 No 1 Yes **Division of Vital** director, 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 Yes 2 🗌 No 1 Inpatient 2 BR/Outpatient 3 IDOA 잍 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After I
completed filled in by the funera 5 Pending iniury 1 Natural 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Homicide Medical 29a Certifie 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination of or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Ceptifying Nurse Practioner: To the best of my browledge, geath occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certif 29c. License number

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

	1	For State Registrar		State of	f Marylar	-	artment of H tificate of D			iene eg. No. 20	10	01470
Physician/	-	. Decedent's Name (Fi							2. Date of Deat	h	Year	3. Time of Death
Medical		Nedra In		iday	ner)		4b. City, Town, or	Location of Doath	January	2, 2010		10:36 A.M
Examiner		Bowie Heal	, ,		,		Bowie	Location of Death		1		orge's
Funeral Director	2	. Social Security Numb 233–42–1964	4 1	× □м 2 Х □ F	7. Age (In yrs. i 87	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, July 11	Year) 1922	9. Birthp Coun Vir	olace (State or Foreign try) ginia
ind show at	- 15	Usual Residence of Dec Oa. State 10	cedent 0b. County	-	10c. Cit	ty, Town or Lo	cation				1	0d. Inside City Limits
Maryla 28a-f s otified	M	laryland	Prince	George'	s Bo	wie						¥⊠ Yes 2 □ No
leath with the Maryland items 23a or 28a-f she er must be notified at Elmeral Director	1 1	0e. Street and Numbe		Lane			10f. Zip Code 20715			10g. Citizen of W	hat Coun A •	ntry?
ffer of the soul o	2	Marital Status Never Married Widowed 4 □		12. Was Deced Armed For 1 Yes If Yes, Give Year or Dat	cesty 2 🗗 No	1	Vas Decedent of His f Yes, specify Cubar I ☐ Yes 2 💢 No	n, Mexican, Puerto			k, White,	an Indian, etc. ite
ithin 72 hours a liene. The Medical Ext		(Specify	5. Decedent's Ec only highest gra			[(Give i	ient's Usual Occupa kind of work done d O NOT use retired)		ing	16b. Kind of Bu	siness Ind	dustry
within 7 giene. er than 4, the Mar		Elementary/Second	lay (0-12)	College (1-	4 or 5+)	I _	etary			Bell A	t1an	tic
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ould boom mark	Ш	Joseph Or:				19h Mailir	ng Address (Street a					Code)
y, Mal	- 11	Melody Wils					01d Chap					,
IOFE,	2	0a. Method of Disposi		Removal from	State (cemetery, cren	sition (Name of natory or other place	e) :		20c. Location -	•	
balumor bernit. Page 1 Department of mportant: If i any injury or or once.		4 ☐ Donation 5 l		<u> </u>	Har	dys Co	rners 2. Name and Addres			Rushford Evans F		
any any any	9	D 90_ 1	Konie	2			6000 Anna					
Physician/	1	23a. Part 1. Enter the a shock, or heart fa Immediate Cause (Fina disease or condition	ailure. List only or	olications that cone cause on each	ch line.		er the mode of dying	j, such as cardiac d	or respiratory arre	est,	2	Approximate Interval Between Onset and Death Welks
Medical Examiner		resulting in death)	ſ	Due to (d	or as a conseq	uence of):						
in the second se		Sequentially list condit if any, leading to imme cause. Enter Underlyin	ediate	Due to (c	or as a conseq	uence of):						
rou cate be executed physician and the burial-transit		Cause (Disease or iinju that initiated events resulting in death) Las	ury	c. Due to (or as a conseq	uence of):					-	
ate be ex physician the buria		,	L	d								
ertificate ding phy se as the		F FEMALE:	1									
death c death c he atten led for u	2	23b. Was decedent pre in the past 12 m 1 ☐ Yes 2 ☐ N 9 ☐ Unknown	hths?		3irth 2 ☐ Fet nant at time of	al death 3	Ectopic pregnanc Other (specify)	у		23d. Date Mor	e of deliventh	ery Day Year
dS, F.C. quires that the an signed by t uld be detach	בי ב	Part II. Other significa	int conditions co	ontributing to de	eath but not re	sulting in the u	ınderlying cause giv	en in Part I.				ne cause of death?
Hecords, The law requires cate has been signage 2 should b.									24a. Was a autop: perfor 1 \(\square\) Yes	sy p med? d	rior to co leath?	psy findings available impletion of cause of
VITAI Kysician: The scertificate director, pa	i i	25. Was case referred to examiner?	71	Hospital:	Inpatient 2	EB/Outnation	Other	er:	ome 5 Resident	anga 6 🗆 Otha	r /Specifi	1
or VII ng Physi ter this c neral dire		27. Manner of Death	Fending	28a. Date of		28b. Time of injury			28d. Describe ho			
or Attending P after death. Director: After t in by the funers		2 Accident	Investigation	_	of Injury - At h	ome form etr	M 1 □	Yes 2 ☐ No	20f Lagation (C)	treet and Numbe	r or Puro	I Pouto Number
DIVISION Tall or Attendir s after death. I Director: After in by the full		4 ∐ Homicide	determined		ig, etc. (Specif		ect, factory, office		City or Town		or nurar	rroute ramos,
To the Hospital or Attending Physical Depth of the Funeral Director: After this completed filled in by the funeral directory. Medical Certificate: Tr		29a. Certifier 1 (Check 2 only one) 3	Medical Exami	ner: On the basi	is of examination	on and/or inves	occured at the time, tigation, in my opinio death occurred at the	n, death occurred a	t the time, date ar	nd place, and due	to the ca	use(s) and manner stated.
To t with	2	29b. Signature and title	e of certifier	1	nm	hu	29c. License	number 2058	2/3	29d. Date signed	(Month,	Day, Year)
45	3	30. Name and address	of person who	empleted caus MALI	e of death (Iter	m 23a) (Type, F	Print) Su	napolis	Rd G	leun Dal	e M.	0 20769
State Registrar	3	31. Date filed (Month, L	N 06 20	10 32.	egistrar's Signa	ature A	ares					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** P^M 1705 2010 David Otis Ferguson January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Ceci1 251 Bouchelle Road North East 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 X M 2 □ F Director NOV 30. 1954 220-62-0329 Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits ortant: If item 27 is marked other than "natural", or items 28a or 28a-f show injury or other traumatic event, the Worldal Examination up the natified at 1 ☐ Yes 2 X No Directo Maryland Ceci1 North East 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 251 Bouchelle Road 21901 United States death v Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event. Black, White, etc. 1 ☐ Never Married 2 X Married 1 □Yes 2 X No Specify: Completed by 3 Widowed 4 Divorced White 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Carpenter Building/Construction Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ruby Opal Matney Otis Leroy Ferguson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra L. Ferguson/Wife 251 Bouchelle Road, North East, MD 21901 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State January 20 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Union Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2010 Union, MD 21. Signa re of Funeral Service Licensee Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, 21921 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician ned for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑ No 24a. Was an has performe this certificate 1 ☐Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2√2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Deat 28a. Date of Injury 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred (Month, Day, Year) 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

State Registrar

29b. Signature and title of certifie

31. Date filed (Month, Day

39. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2010

32. Regist

29c. License number

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month 3. Time of Death Year **Physician** P^{M} Paul Lamont Gray 2010 2024 January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Union Hospital E1kton Cecil If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 X M 2 □ F Director 79 AUG 21. 1930 Delaware 218-28-2061 Usual Residence of Decedent 10c. City, Town or Location 10d Inside City Limits 10a. State 10b. County show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Exandract must be muffled at 1 ☐ Yes 2 X No Directo Maryland Ceci1 Rising Sun 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 352 Fell Road 21911 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 🕅 Married altimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 📉 No Specify Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Heavy Equipment Mechanic Trucking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Raymond J. Gray Mabel Getty ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Janet E. Youse/Daughter 105 Farah Drive. Elkton, MD 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cometery, crematory or other place) Date January 20 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Rose Bank Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2010 Calvert, MD 22. Name and Address of Facility
Hicks Home for Funerals, P.A.
103 W. Stockton Street, Elkton, 21. Signature of Funeral Service Licensee 21921 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Acute /Medical Due to (or as a consequence of): Examiner desce and severe averying resumed coroger Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the death certificate be executed Upper 64stro14testina ng physician and as the burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical signed by the attending p IF FEMALE: ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Tinknown The law requires that 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 2 XNo 1 ☐ Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has tuneral director, page 2 s autopsy performed? 1 ☐Yes 2 ☐ No 1 ☐Yes 2 No To the Hospital or Attending Physician: 'within 24 hours after death.

To the Funeral Director; After this certifica completely filled in by the funeral director, p 25. Was case referred to medical Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No 1 Tes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 ₩atural 5 | Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 ☐ Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number EL my my as 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hospital 106 Bow Street El U4104 410 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Barbara Lee Gold January 6 2010 3:25 Medical a 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Casey House Montgomery Rockville Social Security Number 6. Sex . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1. M 2 X F Months Davs Hours Country) Wisconsin Director 72 388-34-8138 067 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 'lem 277 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at within 72 hours after death with the Maryland Director 10d. Inside City Limits 1 🗌 Yes 2 🛣 No Rockville Maryland| Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 14403 Barkwood Drive 20853-2313 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🖾 No Specify: Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. is marked other than Elementary School Teacher Elementary/Seconday (0-12) College (1-4 or 5+) Elementary Education Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other traumationones. မ Goldye Phillips Dr. Jacob Serge 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14403 Barkwood Drive, Rockville, MD 20853-2313 Sanford L. Gold, husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State competery, crematory or other place)
B nai Israel
ongregation Cemetery 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State 01/07/2010 4 Donation 5 Other (Specify) Oxon Hill, Maryland Signature of Juneral Service Licensee 22. Name and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, INC. asse MO1255 1091 Rockville Pike, Rockville, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ Metastatic Pancreatic Cancer Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to for as a consequence on attending physician and I for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Day Year signed by the a d be detached for 2 🔀 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy performe To the Funeral Director: After this certificate of completed filled in by the funeral director, page 2 🗌 No Yes 2X No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 1 Tes 2 😾 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 □ Nursing Home 5 □ Residence 6 ☒ Other (Specify) Hospice Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred injury 1 X Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

within 24 hours a To the Funeral D

Registrar

29b. Signature and title of certifier

I wucetcheu, mis

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jocelyne Toukep Kouatchou, 21 East University Parkway, Baltimore, Maryland

D63748

29d. Date signed (Month. Dav. Year)

January 6, 2010

			for State State Registrar	of Marylar		artment of H <i>tificate of L</i>		lental Hygie _{Reg.}	2010	01474
	Physicia	an	1. Decedent's Name (First, Middle, Last)					Date of Death Month	Day Year	3. Time of Death
	/Medic	al	Carmelita Galar			4h City Town or	Location of Death	January	7 2010 4c. County of Death	1:30 A.M
	Examin	er	4a. Facility Name (If not institution, give street and 19301 Club House Road				omery Vi	11200	Montgome	
	Funeral		Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	if Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye April 13		place (State or Foreign
	Director		212 - 59-7540 1□ M 2∑	F 63	Yrs.	WOTHIS Days	riouis Iviiii,	April 13	,1946 Phil	intry) Lippines
	and ow		Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ity, Town or Lo	cation				10d. Inside City Limits
	Mary a-f she	tor	MD Montgomery		Me	ontgomery	Village			1 □Yes 2 □No
	or 28	Funeral Director	10e. Street and Number 19301 Club House Road	#102		10f. Zip Code 208	0.6		Citizen of What Cou	•
	eath w	eral	1	Oecedent Ever in U	IS 13 V				Philippine	
9500	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tiem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evantine must be notified at once.	þ	1 Never Married 2 Married 1 Yes	iForces? es 2⊠No		fYes, specify Cuba ! □Yes 2 🛣No	Ispanic Origin? (Spin, Mexican, Puerto Specify:	Rican, etc.)	Black, White,	
2	"natur	Completed	15. Decedent's Education (Specify only highest grade complet	∍d)	16a. Deced	dent's Usual Occupa	ation during most of worki ')	ing 168	o. Kind of Business/Ir	ndustry
7	within lene. than he Me	dwo	Elementary/Secondary (0-12) Collect	e (1-4or 5+)		estic Coo			Private Ho	am A
2	e filed Il Hyg other	BeC	17. Father's Name (First, Middle, Last)	<u>, </u>	, Dom			e (First, Middle, Mai		onic .
<u> a </u>	uld be Menta arked artic ev	70 E	Diosdado Lagandaon					Lcantara		
la	2 sho n and Is ma		19a. Informant's Name/Relationship (Type. Print)		19b. Mailin	ng Address (Street a	and Number or Rura	al Route Number, C	ity or Town, State, Z	ip Code) 20886
a) E	1 and Health em 27 ther t		Jemellie Galang /Daugh 20a. Method of Disposition						gomery Vi	
baitimor	t. Pages rtment of rtant: If its njury or o		1 X Burial 2 ☐ Cremation 3 ☐ Removal fr 4 ☐ Donation 5 ☐ Other (Specify)	om State Hi	mlayang	sition (Name of natory or other plac Filipino	201	arv 17 Ta	andang Sor Quezon Ci	a
ם O	permi Depa Impo any i		21. Signature of Funeral Service Incansee IRACHA: Hay BA	Mont		Name and Address NeVol Fundanthersb		08 ¹⁰ East	Deer Par	k Drive,
			23a. Part1. Enter the disease, or complications the shock, or heart failure. List only one cause	at caused the deat on each line.	th. Do not ente	er the mode of dyin	g, such as cardiac	or respiratory arrest	,	Approximate Interval Between Onset and Death
	Physician /Medical		resulting in death)			Cancer t	o Lung an	nd Bone		2 yrs 4 mo.
r	Examiner		(1)	to (or as a consec	quence or):					
	± 0	ner	Sequentially list conditions, if any leading to minediate cause. Enter Underlying Cause (Disease or injury	tu (or as a consec	quence of):					
)	ecute and I-trans	Examiner	triat initiated events	to (or as a consec	mence of).	··· <u>-</u>				
00/00	ifficate be executed g physician and as the burial-transit	edical E	d.	(,					
0	± m ∞	/ledi	IF FFMALE							
C. Box	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. Within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	hysician/M	in the past 12 months?	outcome of pregn ive birth 2 ☐ Feta regnant at time of Inknown	al death 3 □	Ectopic pregnancy Other (specify)	У		23d. Date of deli Month	very Day Year
J,	res that signed b be deta	by P	Part II. Other significant conditions contributing	o death but not res	sulting in the ur	nderlying cause give	en in Part I.		co use contribute to	the cause of death?
cords	requi	eted							Δ	
al ne	1; The law ficate has r, page 2 s	Completed						24a. Was an autopsy performe 1 □ Yes 2 ∑	prior to c death?	topsy findings available completion of cause of
	/sfcia s certi lirecto	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No Hospital:	☐ Inpatient 2 ☐	TER/Outnatien	ot 3 DOA Othe		h (Check only one)	e 6 Other (Spec	n(6,1)
5	ng Phy fter thii neral c	on: To	27. Manner of Death 28a. D	ate of Injury Month, Day, Year)	28b. Time of Injury		y at	28d. Describe how		
SION	tendir eath. or: Al	catic	2 Accident investigation			M 1 □	Yes 2 □ No			
DIVIS	al or At after d Direct d in by	Certification:	determined 286. P	lace of Injury - At h uilding, etc. <i>(Speci</i>	nome, farm, stro ify)	eet, factory, office		28f. Location (Stree City or Town, S	et and Number or Ru State)	ral Route Number,
	ne Hospita n 24 hours ne Funera pletely fille	Medical C	29a. Certifier (Check only one) 1							
	Vithi Vithi Comp	M	29b. Signature and title of certifier	1	,	29c. Licens			. Date signed (Month	
	12		Many OHE	ndr	Mo) / DU	037236	J	Tanuary 7,	2010
			30. Name and address of Jerson who completed Carolyn B. Hendricks,	M.d., 6	410 Roc	kledge D	rive, Bet	hesda , M	D 20817	
	Sta Registr		31. Date filed (Month, Day, Year) JAN 08 2010	2. Registrar's Sign	ature_	K. J.				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Jan 8. 2010 **Physician** 1:53 P M Grover Guessford Charles /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5904 Delta Lane Camp Springs Prince George's If Under 1 Year | If Under 24 Hrs. 6. Sex 1 **M** M 2 □ F 8. Date of Birth (Month, Day, Year) July 25, 1 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Days Hours July 81 1928 Maryland Director 215 20 9409 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10h County 10a. State 1 ☐ Yes 2 No ral", or items 23a or 28a-f st Examiner must be notified Camp Springs Director Maryland Prince George's 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20746 United States 5904 Delta Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. and 2 should be filed within 72 hours after 1 ♥ Yes 2 □ No If Yes, Give Year or Dates: 1945-1954 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: White þ 3 Widowed 4 Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) other than Pile Driver/ Driver Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental Grover Cleveland Guessford Jessie M. Potter ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Teresa Guessford / Wife 5904 Delta Lane, Camp Springs, MD 20746 27 20b. Place of Disposition (Name of cemetery, crematory or other place) Feb 5, 2010 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of F
Important: If ite
any Injury or ot
once. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Arlington National Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Arlington, Virgina 21. Signature of Funeral Se Acceline 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d 23a. Part 1: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of hear failure. List only one cause on each line.

Immediate trause (Final disease of condition resulting in death)

a. Atherosclerotic Heart Disease Alexandria Ferry Road, Clinton, MD Approximate Interval Between Onset and Death **Physician** /Medical Due to (or as a consequence of): Examiner Peripheral Vascular Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine that the death certificate be executed Diabetes Mellitus Type II Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) P.0. 9 I I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 💢 No 3 ☐ Probably 4 🗌 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Wasan autopsy performed? Yes 2 \(\square\) No 2 No 1 TYes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home XX Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending ours after death.

leral Director: Ai
filled in by the fu 1 ☐Yes 2 ☐ No investigation 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a 29a. Certifier **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou To the Fune completely fi Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar

Name and address of person who completed cause of death (Item 23a) (Type, Print) Robin Peck, M.D. 6022 Walhondeng Road, Bethesda, MD 20816 31. Date filed (Month, (Month, Day, Year) JAN 12 2010

32. Registrar's Signature

31139

Jan 11, 2010

Registrar

Saltimore, Maryland 21215-0036

P.O. Box 68760,

of Vital Records,

Division

		For State Registrar	State of Mary	land / Depa		lealth and	Mental Hy	giene Reg. No. 201	0 0147
Physic /Medi	cal	Decedent's Name (First, Middle, Pliny Guernsey Aa. Facility Name (If not institution, §	Holt		Ab. Cib. Tours		2. Date of Dea Month January	Day 2010	5:15 A ^M
Exami Funeral Director	۲	8813 Stonehaven	Drive	yrs. last birthday) Yrs.	Potomac If Under 1 Year Months Days		s. 8. Date of Birt	4c. County of D Montgom h y, Year) 910 Ca	
with the Maryland a or 28a-f show	ector	Usual Residence of Decedent	100	c. City, Town or Lo					10d. Inside City Limits 1 ☑ Yes 2 ☐ No
th with th	ral Dire	10e. Street and Number 8813 Stonehaven	Drive		10f. Zip Code 20854			10g. Citizen of What United St	
5-0036 72 hours after death with the Maryla natural", or items 23a or 28a-f shoulded Examiner must be rediffed at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ሺ Divorced	12. Was Decedent Ever Armed Forces? 1 XYes 2 □ No If Yes, Give 19 Year or Dates:	in U.S. 13.	Was Decedent of H If Yes, specity Cuba 1 □Yes 2 🏋 No		Specify Yes or No- rto Rican, etc.)	14. Race - A Black, W Specify: W	
21215-003 within 72 hours jiene. r than "natural", the Medical Exp	Completed	15. Decedent's (Specify only highest of Elementary/Secondary (0-12)	Education grade completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done o DO NOT use retired	during most of wo f)	orking	16b. Kind of Busine Military	ss/Industry
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours att Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or may injury or other traumatic event, the Medical Examples.	To Be C	17. Father's Name (First, Middle, La Pliny Eastman Ho	olt			18. Mother's Na Florence	e Guerns	Maiden Surname) ey	
e, Mal I and 2 st Health an I'm 27 is r		Joel Labow / fri	lend	1023	4 Arizona		Bethes	da, MD 20	817
Baltimore, Marylar permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evonce.		20a. Method of Disposition 1 □ Burial 2 ▼ Cremation 3 4 □ Donation 5 □ Other (Spec	Removal from State		cremator Cremator	1			urch, Virgini
Bal permi Depa Impo		(ARTICID)	M	101255	D 1170 Ro	anzamsky ckville	-Goldber Pike Ro	g Memoria ckville,	1 Chapels, Inc
Physician /Medical		23a. Part1. Inter the lisease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	y one cause on each line. Inanit: Due to (or as a con	ion	er the mode of dyin	g, such as cardia	ac or respiratory ar	rest,	Approximate Interval Between Onset and Death 1 week
68760, Ifficate be executed with a physician and was the burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a con	sequence of): y Renal (Liver, Lu Cancer	n, Bone	2		12 Months 4 years
O. Box he death cer the attendin	by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pre 1 □ Live birth 2 □ I 4 □ Pregnant at time 9 □ Unknown	Fetal déath 3 🛚	Ectopic pregnancy Other (specify)	/		23d. Date of Month	delivery Day Year
ords, P. quires that the signed by ould be detact	ed by Pr	Part II. Other significant conditions	contributing to death but not	resulting in the ur	nderlying cause give	en in Part I.	23e. Did to	_	e to the cause of death? Probably 4 Unknown
al Records, : The law requires t cate has been signe, page 2 should be c	Completed						24a. Was a autop perfor 1 □ Yes	sy prior med? death	autopsy findings available to completion of cause of ?? 'es 2 □ No
f Vital ysician: Tl is certificate director, pa	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital:	2 ☐ ER/Outpatien	t 3 TI DOA Othe		ath (Check only or	ne) ence 6 □Other (S	(maniful)
Division of I or Attending Physafter death. Director: After this Jin by the funeral di	Certification: To	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigati 3 ☐ Suicide 6 ☐ Could not	28a. Date of Injury (Month, Day, Yea	r) 28b. Time of Injury	28c. Injury Work M 1 🗆 Y			ow injury occurred	респу
DIVI spital or At ours after or eral Directilled in by		4 ☐ Homicide determine	building, etc. (Sp	pecify)		ne date and ne	City or Tow	n, State)	Rural Route Number,
the Hos hin 24 h the Fun πpletely	Medical		Physician: To the best of my aminer: On the basis of examiner and manner stated.	mination and/or in			urred at the time,	date and place, and c	r as stated. flue to the cause(s)
P ₹ P Ø	~	29b. Signature and tale of certifier	w		29c. License D263		2	January 4	
		30. Name and address of person who	. 10234 Ariz	ona Circ		esda, MD	20817		
Sta Registr		31. Date filed (Month, Day, Year) JAN 08 20	32. Registrar's Si	gnature					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Mildred Virginia Hein 03% A^{M} Jan. 2010 9:15 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City Town, or Location of Death 4c. County of Death Examiner Anne Arundel Heartlands Severna Park If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 93 Months 1 □ M 2 🕅 F 216-05-0098 30, Director May 1916 Maryland Usual Residence of Decedent 10a. State 10b. County show 10c. City. Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if Item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, Inc. Nedical Examinationals but officed. MD Anne Arundel Severna Park Director 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 715 Benfield Road 21146 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian Black, White, etc. 1 Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 TYes 2 No. Specify 2 3 ₩ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) American Health Elementary/Secondary (0-12) College (1-4or 5+) and Life Insurance 12 Executive Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Milton Braun ٥ Bertha Karsten 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kenneth D. Hein/Son 714 Ticonderoga Ave. Severna Park, MD 21146 Date 9, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Jan. 2010 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Parkwood Cemetery Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice 22. Name and Address of Facility Barranco & Sons, 495 Gov. Ritchie P.A. Severna Park Funeral H Hwy. Severna Park, MD 21146 Home Hwy. 23a. Park. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Carebronasman Picease disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Linter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Examir and Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medical the as for use a IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ð icate has been si page 2 should b 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate 1 ☐ Yes 1 ☐ Yes 2 ☐ No this certific al director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2. No ဥ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After 1 28c. Injury at Work? Medical Certification: 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 1 □Yes 2 □No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number MO 550108 2010

State Registrar Michael

31. Date filed (Month, Day,

Suite Zão

Wen Burnie

1845 Outwood Rd

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DOWNING

Year)

JAN 06 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 20Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Year *INAPERA* 3,50 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Sunrise Assisted Living Severna Park 8. Date of Birth (Month, Day, Ye Aug. 24, 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Year) 1959 Washington D.C. Months Days Hours Min 213-50-2059 50 **Director** Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location s 23a or 28a-f show 10d. Inside City Limits Director MD Anne Arundel Annapolis 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3705 Thomas Point Road 21403 USA Funeral ed other than "natural", or items event, the Medical Examination 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 ⊠No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify \$ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, II s. IM. Elementary/Secondary (0-12) College (1-4or 5+) Federal Government <u>Civilian Personel Specialist</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Anapera Kellett Charles Arthur Fisher ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anapera K. Fisher/Mother 3705 Thomas Point Road Annapolis, MD, 21403 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Jan. 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Atlantic Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2010 Glen Burnie, MD 21. Signature of Puneral Service Licenses 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy. Severna Park, MD 21146 23a. Pp. 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** HEAR /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Box 68760, attending physician Physician/Medical the as IF FEMALE: asn yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Ď in the past 12 months? 1 ☐ Yes 2 X No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) signed by the P.0. 9 Unknown 9 Unkno Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has bage 2 s autopsy performe r this certificate h ral director, page 1 □ Yes 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral c 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Iniury within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 2 Accident 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only 29b. Signature and title of certifier 29c. License numbe

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

Year)

JAN 06

		Please Type or Print in				•	_	
		State of Mary	•	artment of H <i>rtificate of l</i>		, ,	2010	01480
		Registrar 1. Decedent's Name (First, Middle, Last)		inicale of t	Jean	2. Date of Dea	th	3. Time of Death
Physicia /Medic		William Howard Higg	ins, Sr			Month January	Day Year 4. 2010	12:17P M
Examin		4a. Facility Name (If not institution, give street and number)			Location of Death		4c. County of Deat	
Funeral		I M ○□ E	yrs. last birthday)	Damascus If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	(Year) Co	hplace (State or Foreign untry)
Director		577-72-0223	54			Jan. 27	, 1955 Mary	Land
ryland thow	_	10a. State 10b. County 10c	. City, Town or Lo	cation				10d. Inside City Limits
filed within 72 hours after death with the Maryland Hygiene. Uther than "natural", or items 23a or 28a-f show ent, the Mydical Examination offited at	Funeral Director		amascus	1404 77 0 4			0.00	1 □Yes 2 No
with the	I Dir	10e. Street and Number		10f. Zip Code 20872			l 0g. Citizen of What Co	untry?
death ms 23	nera	26015 Brigadier Place, Unit E 11. Marital Status 12. Was Decedent Ever	in U.S. 13. V		ispanic Origin? (Sp in, Mexican, Puerto		14. Race - Ame	
after or ite		1 Never Married 2 Narried 1 Never Married 2 Narried 1 Never 1 Narried 1 Never Married 1 Never		ryes, specify Cuba i⊡Yes 21XINo	Specify:	Hican, etc.)	Black, White	e, etc.
hours tural";	ed by	3 ☐ Wildowed 4 ☐ Divorced Year or Dates:		dent's Usual Occup			Whi	
in 72 n "nat	plete	15. Decedent's Education (Specify only highest grade completed)	(Give	kind of work done of NOT use retired	during most of work f)	ing	Montgomery	·
d with giene er tha	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	Mecha	nic			Public Sch	_
be file tal Hy d othe event,	Be	17. Father's Name (First, Middle, Last)			18. Mother's Name	(First, Middle, i	Maiden Surname)	
d Men	ို	Carroll Montgomery Higgins	10. 11.		Ida Belle			7: 0:4:) 00070
id 2 sh lth an 27 Isr		19a. Informant's Name/Relationship (Type. Print) Cindy L. Sparrow Higgins, wif					r, City or Town, State, 2	
s 1 ar of Hea ltem;		20a. Method of Disposition 20		sition (Name of natory or other place			20c. Location - City or	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Eval, intrinst be refifted and once.		To buildi 2 Dicientation 3 Directioval notificate			1	/2010	Alexandria	, Virginia
epartr epartr nporta ny inj		21. Signature of Funeral Service Licensee	22	. Name and Addres	ss of Facility Mo	Lesworth	-Williams	Funeral Home
ă.○ <u>=</u> ≅ ĕ	7	Syan M. Dy					, Maryland	20872 Approximate
Physician /Medical		23a. Part 1. enter the disease, or complications that crused the shock or leart failure. List only one cause on each line. Immediate cau e (Final disease or condition resulting in death)	nto 17	INSTHE	1201	or respiratory an	651,	Interval Between Onset and Death
Examiner		Due to a r as a cor	sequence of):	latul:	Scienson			
	ner	Se uentially list conditions. If any, leading to immediate Cause Enter Underlying	nsequence of):		0-015			
oe executed cian and urial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C						
icate be ex physician a the burial-		2 200 10 (01 20 2 00)	isequence of):					
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h cert ending	M/UE	IF FEMALE: 23b. If yes, outcome of pr 23b. In the decedent pregnant 1 ☐ Live birth 2 ☐		Ectopic pregnanc			23d. Date of de	livery
e deat	Physician/Medical	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown in the past 12 months? 4 □ Pregnant at time 9 □ Unknown		Other (specify)	у		Month	Day Year
that the ed by detach		Part II. Other significant conditions contributing to death but not	t resulting in the ur	nderlying cause give	en in Part I.	23e. Did to	bacco use contribute to	the cause of death?
quires n sign	d by					1 🗆 Y	es 2X1 No 3 □ P	robably 4 🗌 Unknown
aw red as bee 2 shot	plete					24a. Was a	n 24b. Were au	utopsy findings available completion of cause of
The I	Completed					autops perfor 1 ☐ Yes	med? death? 2 ∏XNo 1 ☐ Yes	
iclan: certific ector,	Be	25. Was case referred to medical examiner? Hospital: Hospital:		Othe	26. Place of Deat	h (Check only or	ne)	
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ath. r: Afte	atio	1 XNatural 5 ☐ Pending (Month, Ďay, Yea 2 ☐ Accident investigation	ar) Injury		(? Yes 2 □ No			
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the buri	Certification: To	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - building, etc. (S)	At home, farm, stre	eet, factory, office		28f. Location (S City or Tow	treet and Number or Ro n, State)	ural Route Number,
spital ours a ours a neral C		29a. Certifier 1 X Certifying Physician: To the best of my	knowledge, death	occurred at the tir	me, date and place.	and due to the	cause(s) and manner a	s stated.
he Hos in 24 h he Fur pletely	Medical	(Check only one) 2 Medical Examiner: On the basis of examiner and manner stated.						
To the to the common co	Σ	29b. Signature and title of certifier		29c. Licenso	e number	2	29d. Date signed (Mont	h, Day, Year)
		Jan 19.		100	38291		January 5,	2010
1041		30. Name and address of person who completed cause of death Charles filed (Month Day York)	(Item 23a) (Type, I	Ls Un'v.	1 600 N.	Wolfe, I	Balkmor 1	2010 7D 4287
Sta Registra		31. Date filed (Month, Day, Year) 32. Registrates S	ignature	faces	•			

DHMH 17 Rev 1/2001

		For State Registrar		State of Ma	ıryland /		rtment of h tificate of	Health and M <i>Death</i>	lental Hy	giene 2 () 0	01481
Physic	ian	1. Decedent's Name							2. Date of De Month	Day	Year	3. Time of Death
/Med	ical	Kenneth 4a. Facility Name (If I	B. Hobli				4h City Town o	r Location of Death	1	4 20	010 ty of Death	8:53 A M
Funeral Director	ľ	331 Robi 5. Social Security Nu 214-22-78	n Dr., A mber 6. Se	pt. 204	e (In yrs. last	birthday) Yrs.	Ocean If Under 1 Year Months Days		8. Date of Bir (Month, Da 10/18/	Word	ceste	
land ow		Usual Residence of D 10a. State	Decedent 10b. County		10c. City, To	own or Loc	cation					10d. Inside City Limits
Mary a-f sh	iot	MD	Worces	ter	0	cean	City					1 XYes 2 No
or 28	Director	10e. Street and Numl	ber				10f. Zip Code			10g. Citizen of	What Cou	ntry?
s 23a		331 Robin	Dr., Ap			145.11	2184			USA		
ING 21213-UU30 be filed within 72 hours after death with the Maryland ntal Hygiene. sd other than "natural", or items 23a or 28a-f show event, it is it added to the control of the cont	by Funeral	11. Marital Status 1 X Never Marrie 3 ☐ Widowed 4		12. Was Decedent E Armed Forces? 1 ▼Yes 2 N If Yes, Give Year or Dates:			vas Decedent of F Yes, specify Cuba □Yes 2XNo	dispanic Origin? (Sp an, Mexican, Puerto Specify:	ecity Yes or No Rican, etc.)	Speci	ace - Ameri ack, White, ify: W	
5-UU36 72 hours aft natural", or	eted	(Specif	15. Decedent's Edu y only highest grad	ucation de completed)	1	6a. Deced	ent's Usual Occup	pation	ina	16b. Kind of E		
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nd ZIZI e filed within al Hygiene. other than "		17. Father's Name (F	First, Middle, Last)	4		ACCO	uncanc	18. Mother's Name	e (First, Middle			ing
aryland should be file and Mental H s marked oth	To Be	C. Lown							B. Unk		,	
Aarylan 2 should be and Mental 1s marked c raumatic ev	-	19a. Informant's Nan	ne/Relationship (T	ype. Print)	1	9b. Mailin	g Address (Street	and Number or Run	al Route Numb	er, City or Towr	n, State, Zi,	o Code)
e, IVI				God Daught				Rd., Bal				
DallIMOre, Marylar permit. Pages 1 and 2 should be Department of Health and Menta Important: if Item 27 is marked any injury or other traumatic ev any, injury or other traumatic ev angles.		4 ☐ Donation 5	Cremation 3 ☐ I			Hen	sition (Name of latory or other place lopen Cre	= m. 1/6/2		20c. Location Frank	ford,	DE
Departing permit Departing		21. Signature of Fun	eral Service Licens		P	100	Name and Addre	am St., B		Funera MD 2181		e
Physician		shock, or heart Immediate Cause (F disease or condition	tailure. List only o inal	lications that caused one cause on each line	the death. De.						3/2	Approximate Interval Between Onset and Death
/ /Medical Examiner		resulting in death)	(Due to (or as a	consequenc	ce of):						
uted d ansit	Examiner	Sequentially list cond if any, leading to imm cause. Enter Underly Cause (Disease or in	itions, lediate ying jury	b. Due to (or as a	consequent	ce of):						
ficate be exect physician and the burial-tra	sal Exa	that initiated events resulting in death) La	st	Due to (or as a	consequenc	ce of):						
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriat-transit	ysician/M	IF FEMALE: 23b. Was decedent p in the past 12 m 1 □ Yes 2 □ 9 □ Unknown	nonths?	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at 9 ☐ Unknown	2 🗌 Fetal dea	ath 3 🗌	Ectopic pregnanc Other (specify) _	у			ate of deliv	ery Day Year
es that es that igned b	by Phys	Part II. Other signific	ant conditions co	ntributing to death bu	t not resulting	g in the un	derlying cause giv	en in Part I.				he cause of death?
requires to see signs hould be a	eted								1 []	Yes 2 No		
al net n: The law ficate has l r, page 2 s	Completed								24a. Was autoj perfo 1 □Yes	an 24b. osy rmed? 2 No	prior to co death? 1 Yes	opsy findings available ompletion of cause of 2 □No
VIL rsicia s certi lirecto	o Be	25. Was case referred examiner? 1 ☑ Yes 2 ☐ N	ri .	Hospital:	nt 2 ☐ ER/	Outpations	2□ DOA Oth	er:		,		
ng Phy ffer this	on: To	27. Manner of Death	5 ☐ Pending	28a. Date of Injury (Month, Day)	y 28t	o. Time of Injury	28c. Injur Worl	y at k?		how injury occu		TY)
Attendi er death. rector: A	Certification:	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	investigation 6 Could not be determined	28e. Place of Injui	ry - At home,	farm, stre	M 1 □	Yes 2 □No			ber or Rur	al Route Number,
spital or ours after leral Dir filled in	3 1		Certifying Phy	rsician: To the best o		dge death	Occurred at the ti	me date and place	City or To		manner ac	hatet
the Hos hin 24 h the Fur mpletely	Medical	(Check only 2 one)	Medical Exami	iner: On the basis of and manner stat	examination	and/or inv	estigation, in my o	ppinion, death occur	red at the time,	date and place	, and due t	o the cause(s)
5		29b. Signature and tit	e of certifier	foures Il	n. N		29c. Licens			29d. Date sign		
, 		30. Name and address	s of person who o	11	ath (Item 23	a) (Type, F	Print)	25	S- C	Make: 11	, ,	MD, 21863
Sta	ate	31. Date filed (Month,	Day, Year)	HOLZWO . 32. Registral	r's Signature	11/1	y, 20	2 1/10 W	1, 31	SURV ITA	4/	12, 2/863
Regist	rar		JAN 08 2	2010 Denn	un p	9. 4	back					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Reg. No.2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ INMAN CAYRON Month 0420 M 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel Social Security Number Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 8 Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 🗆 M 2 🗷 Months Days Hours Min 9/1/1926 245-26-3686 Virginia **Director** 83 Usual Residence of Decedent 10a. State 10b. County the Maryland 10c. City. Town or Location 10d. Inside City Limits Director notified 1 Yes 2 No 28a-f Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 5 10g. Citizen of What Country? ms 23a or must be r Funeral 6303 River Crescent Drive 21401 USA items Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Health and Mental Hygiene. tem 27 is marked other than "natural", or itel other traumatic event, the Medical Examiner. Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: 3 X Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) 12th College (1-4 or 5+) Secretary Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Carlton Carter Anna Wallace Noel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any injury or other to 1875 Cherry Rd., Beverly I. Hay/ Daughter Annapolis. Marvland 21409 20b. Place of Disposition (Name of cemetery, crematory or other place)
Parklawn Cemetery 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Durial 2 Cremation 3 Removal from State Rockville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 1/9/10 21. Sign 22. Name and Address of Facility George P. Kalas Funeral Home Þ 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury as been signed by the attending physician and 2 should be detached for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physicial P.O. Box 68760 IF FEMALE s, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown 4 Pregnant 9 Unknown Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page performed 1 ☐ Yes 2 ☐ No Yes 2 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred iniun 1 A Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) the within To the 29b. Signature and title of 29c. License number 0 29d. Date signed (Month, Day, Year) 1438 06,2010

Registrar

State

Defense HWY.

Annapolis

MD 21401

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

445

32. Registrar's Signature

Michael Lapenta

JAN 0

31. Date filed (Month, Day, Year)

10-00383 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Mathias Larnell Johnson State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle Last) Physician/ 3. Time of Death Month Day January 13, 2010 Medical Examiner 0635 hrs MATHIAS LARNELL JOHNSON 4a Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Harford Memorial Hospital Harve de Grace Harford 5. Social Security Number 212-72-1027 If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Director 1 X M 02/08/1962 Usual Residence of Decedent 10a. State 10c. City. Town or Location 10d. Inside City Limits 10b County MD HARFORD ABERDEEN 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21001 CORNELSTREET **HSA** 601 Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. 14. Race - American Indian, Black. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 X Never Married 2 Married Yes 3 Widowed 1 Yes 2 No specify: 4 Divorced If Yes, Give Year BLACK Specify: \$ permit Pages I and 2 should be filed within 72 hours:
Deparment of Health and Montal Hygiene.
Important: If item 27 is marked other than "natur:
injury or other traumatic event, the Medital Exami 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) marked other than 'c event, the Medical Baltimore, MD 21215-0036 12th Fork Lift Driver KDT Inc. 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) HERSCHEL F. JOHNSON CHARLOTTE HUGHES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6004 DOBSON ROAD HURLOCK, MD CHARLOTTE HUGHES (MOTHER) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 1 K Burial 2 Cremation 3 Removal from State crematory or other place) PETERSBURG CEMETERY 01/19/10 HURLOCK, Donation 5 Other Specify: 21 Signature of Funeral Service Licensee 22. Name and Address of Facility Bennie Smith Funeral Home mmie Easton. 21601 Part I. Enter the disease, &complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Medical Death Hypertensive atherosclerotic cardiovascular disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) hysician/Medical PII per ME g904 6/30/10 TT 23a,27,permE, g900 2/17/10 TT X UNPENDED AMENDED attending physician or use as the burial Box 68760, IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown <u>Р</u> О Part II. Other significant conditions 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I \$ 1 Yes 2 No 3 Probably 4 V Unknown Narcotic use Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? page ✓ Yes 2 No 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Hospital: 1 Inpatient Other Nursing Home 5 Residence 6 Other 2 Ker/Outpatient 3 DOA this 1 V Yes After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d Describe how injury occurred Certification: 1 X Natural Pending 1 Yes 2 No the Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) determined Homicide 29a. Certifier 1 [

the Hospital or Attending Physician: within 24 hours after death To the Funeral Director:

Medical 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a)

State Registrar

Zabiullah Ali, M.D.

Assistant Medical Examiner 32. R. gistrar's Signature

and manner stated

111 Penn Street, Baltimore, MD 21201

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

January 14, 2010

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month Paul S. Jaffe 2010 January 2:45 p Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death Montgomery General Hospital Montgomery Olney 9. Birthplace (State or Foreign Country) Poland 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Social Security Number 8. Date of Birth Days 1 🛛 M 2 🗆 F 0*7*776674920 **Director** 262-20-2471 89 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at Director Silver Spring 1X Yes 2 ☐ No Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20906 USA 3330 N. Leisure World Blvd. #619 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. β 1 Never Married 2 Married 1 Yes 2 2 X No Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2X No Specify: "natural", Completed 3

Widowed 4 □ Divorced Specify: White Year or Dates event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Mental Hygiene. Engineer/Artist Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Malka Goldberg Julius Joffe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mona Jaffe Rowe, daughter 22 Rich Branch Court, Gaithersburg, Maryland 20878 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 XBurial 2 Cremation 3 X Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King David Meml Gdns 01/07/2010 Falls Church, Virginia gnature if Fun all Service Licensee EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 Rockville Pike, Rockville, Maryland 20852 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. mediate Cause (Final Onset and Death Phusician/ Medical resulting in death) Due to (or as consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Cause (Disease or iinjury that initiated events resulting in death) Last the burial-transi ate has been signed by the attending physician and page 2 should be detached for use as the burial-trar that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by To the Hospital or Attending Physician: The law requires within 24 hours after death. 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate 21 within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 Tes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 28a. Date of injury (Month, Day, Year) 27. Magner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 29d. Date/signed (Mgnth, Day, Year) person who completed cause of death (Item 23a) (Type, Print) Dr. Vladimir M. Rakhamanin

State Registrar Date filed (Month.

Day, Year) 0 8 2010 Prince Philip Drive,

Olney, Maryland

18101

32. Registrar's S

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2010 Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Day **Physician** <u>7:</u>45P[™] Edna Marie Jenkins January 2, 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 16005 Prince Frederick Road Hughesville Charles 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 T F Months Days Hours Min 220-48-2159 100 Director February 15,1909 Ohio Usual Residence of Decedent 10c. City, Town or Location show 10a. State 10b. County 10d. Inside City Limits Department of Health and Mental Hygiens (Linux) suiter greatn with the Maryla Inportant: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the invited Evantual be notified at once. Director 1 ☐ Yes 2 No MD Charles Hughesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 16005 Prince Frederick Road 20637 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 ☑ No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify White ģ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Eing Mary Baldy ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jackie Morrill/Daughter P.O. Box 118, Hughesville, MD 20637 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State St. Mary's Bryantown 1/8/2010 Bryantown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signalure Funeral Service Licensee ²²AREHART-ECHOLS FUNERAL HOME, P.A. aw Coho St. Mary's Ave. La Plata, MD 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on Lach line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician D Uascu disease or condition resulting in death) >/Medical (or as a consequence of): Examiner 0 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) requires that the death certificate be executed sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. physician Physician/Medical the use as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown 9 Unknown signed by the detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown should The law r 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform After this certificate 1 ☐ Yes 2 🗆 No 1 □Yes 2 XNo or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Yes 2X No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital c within 24 hours af To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical completely 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 30. Name and address of person who complete ed cause of death (Item 23a) (Type, Print) Jonathan Lowenthal, M.D. 10845 Town Center Blvd. Dunkirk, MD 20754 32. Registrar's Signature 31. Date filed (Month, Day, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Month Jane Elizabeth Jurew 2010 9:00 P M Medical lanuarv 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death LaPlata Charles County Nursing & Rehab Charles 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 □ M 2 💢 F Days Min 1927 Illinois Director 577-14-3516 82 November Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director X☐ Yes 2 ☐ No Maryland Charles Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11652 Cygnet Drive 20601 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: "natural", Specify: White 3 **X** Widowed 4 □ Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Educational Instructor <u>|Chicago Park District</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental H Louis Goldberg Margaret 0'Donnell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health Mark Jurew/ Son 11652 Cygnet Drive, Waldorf, Maryland 20601 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 a Department of H Important: If ite any injury or otl cemetery, crematory or other place. 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 01/14/2010 of Heaven Cem. 22. Name and Address of Facility Huntt Funeral Home 21. Signature of Funeral Service Licens MØ1/90 3035 Old Washington Rd. Waldorf, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Failure to thive Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner PREUMUNIA weeks Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examin physician and s the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown 4 ☐ Pregnant at time of death 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Chronic Kidney disease, 1 Yes 2 No 3 Probably 4 Unknown atrial fibrillation, 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No tumar - cranitomy mastectony 1 Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Defining Home 5 - Residence 6 - Other (Specify) ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manne of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of e Hospital or Attending Pl 124 hours after death. e Funeral Director: After the pleted filled in by the funera Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 🗆 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier

Baltimore, Maryland 21215-0036

68760

Records,

Division of Vital

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

.SINGhwani

32. Flegistrar's Signature

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11350 Remprook Sugre Suite, Waldorf, Nd. 20602

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	10-00251 Ameni	ե #	Oa &19b Please Type	or Print in Blac	k Indeli	ble lnk.	Ensu	re All Co	pies Are L	egible.) .	
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	leath r item	Funeral	1 Never Married 2 X Marrie	Armed Forces?	No	If Yes, spe	ecify Cuba	n, Mexican, P	uerto Rican, etc.)		White, etc.	
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	6 72 h an "n cal E	lete	Elementary/Secondary (0-12)	College (1-4 or 5+)		ŭ	J		,		~ .	~
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	Ore ges 1, rof H ther		1 X Burial 2 Cremation 3		cremate	ory or other plac	ce)		-19-10			
	Baltimore, permit. Pages I ar Department of Hee Important: If ite		4 Donation 5 Other Specif		Mary	land V						lle, Md.
	Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Lice		- 0				ons Mor Annapol	_		
	Physician		23a. Part I. Enter the discusse, or com	plications that caused the	death. Do no	t t enter the mod	e of dvina	such as card	iac or respiratory a	arrest sho	ck. or heart	Approximate Interval
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	687 ertific ding	ian/	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2	Fetal deal	th 3	Ectopic pr	egnancy		Month [Day Year
	eath c	sic	1 Yes 2 No 9 Unknow	4 Pregnant at time death Unknown	5	Other (S	pecify)					
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	ds, equir	Completed								is an	24b. Were au	topsy findings available
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0	Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical		r:On the basis of examinat and manner stated.								
	E * E 8	§	29b. Signature and title of certifier	and mariner stated.	_	2	9c. Licens	se number		29d. D	ate signed (Moi	nth, Day, Year)
			sert 6	< a)			O.C.	M.E.		Janu	ıary 9, 2010	
			30. Name and address of person who	completed cause of death	(Item 23a)							
	0/,0			Assistant Medical E	xaminer	111 Penn	Street	Baltimore	MD 21201			
		ate	31. Date filed (Month, Pay Year) 2010	62. Registrar's Si						•		
	Regist	trar	JAN EU ZUIL	Serena	O. 10	arked						

DHMH 17 Rev 1/2001

State

Registrar

Box 68760.

P.0.

Division of Vital Records.

32. Registrar's Signature

Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2010 Joseph Alan Kahl January 9:40 P M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Eden Home Assisted Living Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthdav) 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) **Funeral** 1**X** M 2□ F Months Days Hours Min 350-18-1102 Director July 26, 1923 86 ΤŢ Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Maryla 28a-f shov DH MD Montgomery Bethesda Director 1 X Yes 2 No the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō items 23a 6602 Greyswood Road 20817 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑Yes 2 □ No Army If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 XNever Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. 2 Specify: White 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than 'any injury or other traumatic event, Item College (1-4or 5+) Elementary/Secondary (0-12) 5+ Professor University 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Samuel Kahl Lillian Simon 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda K. Wiesman / niece 306 Inspiration Lane Gaithersburg, MD 20878 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) Date 1 ☐ Burial 2 🖾 Cremation 3 🖾 Removal from State National Crematory Jan. 7, 2010 Falls Church, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fune all Service Licensee Edward Sage1 22. Name and Address of Facility - Goldberg Memorial Chapels, Inc. 1170 Rockville Pike Rockville, MD 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Atherosclerotic Cardiovascular Disease /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner Due to lor as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) Ö 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an as 2 perform 1 □Yes 2 🗓 No 1 ☐ Yes 2 🗆 No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Assisted
4 Nursing Home 5 Residence 6 DOther (SpecifyLiving Other: 1 ☐ Yes 2 ☑ No Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No neral Director: / 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) H45839 January 4, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

Gary E. Raffel, D.O., FACP

2010

31. Date filed (Month, Day, Year JAN 07

32 Registrar's Signat

11119 Rockville Pike #316

Rockville, MD 20852

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Thomas Bruce KUNKLEMAN, SR. 5:12a.M January 9, 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 17211 West Washington Street Hagerstown Washington 8. Date of Birth (Month, Day, Year)
Dec. 25, 1 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign
Country) 6. Sex 7. Age (In vrs. last birthday) Funeral Months Days Hours 1 X M 2 □ F 217-12-1410 85 Yrs. 1924 Pennsylvania Director Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene.
Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examination and the results of the Medical Examination. 1 ☐ Yes 2X No Director Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17211 West Washington Street 21740 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1943-1 ☐ Yes 2 🖾 No Specify: white 2 Specify: 3 ☑ Widowed 4 ☐ Divorced 1946 Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) brakeman railroad 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Kunkleman Ott ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important; If Item 27 is any Injury or other trau Kathy J. Pickens - daughter 11761 Rocky Meadow Road, Clear Spring, Maryland 21722 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Rest Haven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland 21740 1800 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lig Immediate Cause (Final disease or condition resulting in death) **Physician** Week. /Medical discare Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) physician a s the burial-Due to (or as a consequence of): Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) 9 Unknown 9 Unknown þ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ar kingmi Mis care 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 1 ☐ Yes 2 ☑ No 2 □ No 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 4 \sum Nursing Home 1 Yes 2 Vo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Pasidence 6 ☐ Other (Specify) this Certification: To 28a. Date of Injury (Month, Day, Year) 27. Mannet of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

3H-5+

or Attending

Hospital

Physician: The law requires that the death certificate be executed

Box 68760,

Ö

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Division of Vital Records,

Baltimore, Maryland 21215-0036

State Registrar

31. Date filed (Month, Day, Year)

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Oak Hill Ave

29b. Signature and title of certifie

di



MD

29c. License number

29d. Date signed (Month, Day, Year)

01, 11, 2010

State of Marylan	d / Department of Health and Me Certificate of Death	ntal Hygiene	0 1
	Certificate of Death	Pag No CUIU	UI

Physician
/Medical
Examiner

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28 or 28a-f show any injury or other traumatic event, the Modical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit 6H-5 Sta Regist

	1 - For State Registrar			State	JI IVIAI	ylariu ,		tificat				lental Hy	reg.	20	10	0	1149	3
an	1, Decedent's Name	e (First, M	iddle, Las	st)								Date of D Month		Day	Year	3. Ti	me of Death	
cal	June		-	Marie_				Keene				Januar		9, 20		2:	50 A	М
ner	4a. Facility Name (I		, 0		,					Location	of Death			4c. County				
	Williams	•								sport	0411			Wash				
	5. Social Security N		6. S	ex □ M 2 🛣 F		In yrs. last	Yrs.	Months	Days	If Under Hours	Min.	8. Date of Bi (Month, D	ay, Ye	ar)	Cou	intry)	State or Fore	∍ign
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	Usual Residence of 10a. State	10b. Cou			10	0c. City, T	own or Loc	ation								10d. Insi	ide Cify Lim	nits
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Ë	11. Marital Status 1 ☐ Never Marri	od 2 🗆 I	Married	Armed F	orces?	11110.0.	10. (1	Yes, spec	ify Cuba	n, Mexica	n, Puerto	ecify Yes or N Rican, etc.)	0-		ck, White,		aii,	
<u>\$</u>	3 Widowed			If Yes, G	2√ No ive X No pates:		1	□Yes 2	2 ∑ No	Specify	:			Specify	Wh:	ite		
Be Completed by		15. Dece	dent's Ed	ucation		1	6a. Deced	ent's Usua	al Occupa	ation			16b	. Kind of B	usiness/Ir	ndustry		
ple		ify only hi	ghest gra	de completed,		-1	(Give I life. E	kind of wor OO NOT us	rk done d se retired,	luring mos)	st of worki	ing	1					
E	Elementary/Seco 12	nuary (0-1	2)	College	(1-4or 5+)	A	dmin:	istra	tive	Ass	istar	nt	(Credit	t			
e O	17. Father's Name	First, Mid	dle, Last)	-								(First, Middle		den Surnan	ne)			
10 E	Joseph L	ougha	an							Her	riet	ta Kla	ns					
-	19a. Informant's Na	ame/Relati	ionship (7	Type. Print)			19b. Mailin	g Address	(Street a	and Numb	er or Rura	al Route Num	ber, Ci	ity or Town,	State, Zi	p Code)		
	Donald P	. Kee	ene/S	Son			501 E	Raven	Cou	rt, (Colle	yville	, T	X 76	5034			
	20a. Method of Disp					20b. Plac	e of Dispos etery, crem					Date	-	. Location -	City or T	own, Sta	ate	
	1 ☐ Burial 2 ☐ 4 ☐ Donation				State		hs bur				/1/./	2010	S	miths	huro	. MD	1	
	21. Signature of Fu			·			22	Name an	d Addres	s of Facili	ty Re	st Have						
	1 5.M	mk	Su	~								ve., H						
	23a. Part 1. Enter the shock, or hea	ne disease	e, or comp	olicate ns that	caused the	e death. [- '									Appro	ximate	
	Immediate Cause	Final	List only	one chuse on	each line.												al Between and Death	
	disease or conditio resulting in death)	n		a	(or as a c		C W	<u>דשלן ל</u>	50	stral	nles	11-16	DUS	Jani	3	-01	n ye	W7
				Due to	120	Tie	i A	lea ~		111	06	tinal					·	
Je.	Sequentially list cor if any, leading to im	nditions, mediate	J	b Due to	(or as a c	onsequen	ce of):	CV		ans	001/							
Examiner	cause. Enter Unde Cause (Disease or that initiated events	riying injury	1	6														
	resulting in death) I	ast	•	Due to	(or as a c	onsequen	ce of):											
edical			·	d														
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2	IF FEMALE: 23b. Was decedent			23c. If yes, ou	tcome of p			Ectopic p	regnanci	,				23d. Da	te of deliv			
Sicie	in the past 12 1 ☐ Yes 2 ☐				nant at tin			Other (sp						Mo	onth	Day	Year	
Physician/M	9 🗆 Unknown			a m OUK	HOWII													
	Part II. Other signif	icant con	ditions co	ontributing to o	leath but n	ot resultin	g in the un	derlying ca	ause give	n in Part	l.	23e. Did	tobacc		tribute to	the caus	e of death?	,
Completed by	Dev	nevi	44									1 🗆	Yes	2 No	3☐ Pro	bably	4 Unkno	wn
plet												24a. Wa					dings availa	
E													opsy formed 2 2	<u>]</u>	death?	2 DN		OI .
BeC	25. Was case refer	red to med	lical							26. Place	e of Death	(Check only	$-\wp$	No	103	2 141		
0	examiner? 1 ☐ Yes 2	No		Hospital: 1 □	Inpatient	2□ER	/Outpatien	t 3 □ DD	Othe	er: 420	ursing Ho	me 5□Res	sidence	e 6 □Oth	ner (Spec	ify)		
Ë	27 Manner of Death	h 5 □ Per	- 41	28a. Date	of Injury		b. Time of Injury	2	8c. Injury Work	y at		28d. Describe	how in	njury occur	red			
atic	2 ☐ Accident	inv	estigation		, ,,			М		Yes 2	No							
tific	3 ☐ Suicide 4 ☐ Homicide		uld not be ermined	286. Plac	e of Injury ling, etc. (- At home Specify)	, farm, stre	et, factory	, office			28f. Location City or To			per or Rur	al Route	Number,	
Çe																		
Medical Certification: To	29a. Certifier (Check only	1 Certi	ifying Ph	ysician: To the	e best of n	ny knowle	dge, death	occurred	at the tin	ne, date a pinion, de	nd place,	and due to th	e caus	e(s) and m	anner as	stated.	nuse(s)	
Medi	one)			and mai	nner stated	1.												
-	29b. Signature and	title of cer	tifler	7/		.1		290	. License	e number			29d.	Date signe	a (Month	, Day, Ye	ear)	
	VA	211	(4	Yan	Mos	V	MI	>	Do	06	32	33	0	111	2/	201	0	
	30. Name and addr	ess of per	son who	completed cau	se of deat			Print)			1			1			7 1 7 2 2	
	Shahi	d	14/6	homo		580		17/4	2777	19	1210	da Co	210	own	MI	> 2	174	2
te	31. Date filed (Mon	th, Day, Ye		$010 \begin{vmatrix} 32.1 \\ 2 \end{vmatrix}$	egistrar's	Signature	1		/		•	0						
ar		JHIE	B I (UIU Z	September 4	A A		STATE OF THE PARTY.										

10-00262

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

/illiam Knode		State of Maryland / Department of Health and Mental -For State Certificate of Death	Hygiene	Reg. No	20	10 01	492
Physician	1/	Registrar 1. Decedent's Name (First, Middle,Last)	Date of D Month		Year	3. Time of Deal	th
Medical Examin		William Raymond KNODE 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of De	January	9, 201	C. County of D	1745 hrs	
		322 Vista Street Hagerstown	outi		Washingto		
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Months Days Hours	4Hrs. 8. Date of Min.	Birth (MN	M/DD/YYYY) 9	. Birthplace (State or Country)	Foreign
Director	L	220-26-6197 1XM 2F 79 Yrs. Months Days Hours	Oct.	25	1930	Maryland	
any	-	Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County	-			10d. Inside City	y Limits
8 .	اءِ	Maryland Washington Hagerstown				1 X Yes 2	No
h the Maryland 3a or 28a-f show otified at once.	rector	10e. Street and Number 10f. Zip Code		10g. Cit	tizen of What	Country?	
th the last or notified	١ٍٰਂ	322 Vista Street 21740			USA	namina tadian Dian	
15-0036 filed within 72 hours after death with the Maryland I Hygiene. dother than "natural", or items 23a or 28a-f she i, the Medical Examiner must he notified at once	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 1 Never Married 2 Married Armed Forces? 13. Was Decedent of Hispanic Origin? 14. Was Decedent of Hispanic Origin? 15. Yes, specify Cuban, Mexican, Pu		No-	White, et	merican Indian, Blac tc.	к,
ifter de	g F	1 X Yes 2 No 3 X Widowed 4 Divorced If Yes, Give Year 1951-53 1 Yes 2 X No specify:			Specify:	White	
hours a		15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind during most of working life, DO NOT use		16b.	Kind of Busine	ess/Industry	
36 in 72 l	blet	Elementary/Secondary (0-12) College (1-4 or 5+)		. Fr.	e o f o b t	Transpart	a+
5-0036 led within 72 hours at typical within 72 hours at the Medical Examin	Completed	12 0 Truck Driver 17. Father's Name (First, Middle, Last) 18.Mother's N	lame (First, Middl			Transport	ation
21215-0036 uld be filed within 7 Mental Hygiene an marked other than market other than 10 mar	B	Raymond William Knode Ethel	Glendor	a Ha	mmond		
MD 212. d 2 should be lth and Menta n 27 is marke	٩	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number					
e, M I and 2 Health item 2	ł	Dary 1 W. Knode - Son 322 Vista Street. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c	Location - Cit	ty or Town, State	
Pages lent of unt: If	-	1 X Ibulial 2 Cleliation 3 Removaliton State	/15/2010	На	agersto	wn, Maryl	and
Baltimore, MD 2121. permit. Pages I and 2 should be fi Department of Health and Mental I Important: If item 27 is marked injury or other traumatic event,	Ī	21. Signature of Funeral Service Licensee 22. Name and Address of Facility	Minnich				
Physician	1	23a. Part I. Enter the disease for complications that caused the death. Do not enter the mode of dying, such as cardi	vd. Hage iac or respiratory	ersto arrest, sh	own, Md hock, or heart	Approximate	
/Medical	ı	failure. List only one cause on each line. Immediate Cause (Final disease a. Hypertensive Atherosclerotic Cardiovascular Disease				Between On Death	
aminer		or condition resulting in death) Due to (or as a consequence of):					
	اةِ	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):					
	Examiner	cause. Enter Underlying Jause (Disease or injury that initiated events resulting in death). Last Due to (or as a consequence of):					
executed lan and al - transit		events resulting in death) Last Due to (or as a consequence or): d.	_				
6 be execute	edical	UNPENDED					
c 6876(certificate ending physuse as the b		IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pr	regnancy	2	3d. Date of de Month		ear
Box 6876 e death certificate the attending phy ed for use as the	Physician/N	past 12 months? 4 Pregnant at time of death 5 Other (Specify)					
· 4 >4	Ξ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	. 23e. D	d tobacc	o use contribu	te to the cause of de	ath?
, P.O	ᅙ	Chronic Obstructive Lung Disease	1 🗌	Yes 2	No 3 ✓	Probably 4 Un	known
rds requi	lete		24a. W	as an		re autopsy findings a r to completion of ca	
of Vital Records, by Physician: The law requirements the this certificate has been some all director, page 2 should	Completed			erformed?		th? Yes 2	No
	Be	25. Was case referred to medical examiner? 4. Inpatient 2 FR/Outcatient 3 DOA Other4 N					
of Vital I	의	1 ✓ Yes 2 No 28a. Date of Injury 28b. Time of Injury 22c. Injury at Work?	lursing Home 5		njury occurred	Other: Scene	
	틸	1 V Natural 5 Pending (Month, Day,Year) 1 Yes 2 No	0				
5 4 5 5 y	Certification	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.		n (Street n, State)	and Number	or Rural Route Numb	per, City
[[] [] [] [] []		4 Homicide determined (Specify) 29a. Certifier 4 Constitute Physicians To the heat of my knowledge death accurred at the time date and place	and due to the		and manner of	a stated	-
the life	Medical	29a. Certifier (Check only one) 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.	red at the time, d	ate and p	olace, and due	to the cause(s)	
To viti	Me	29b. Signature and title of certifier 29c. License number		290	d. Date signed	(Month, Day, Year)	
		Cerrol Hellan O.C.M.E.		Ja	nuary 10, 2	2010	
3H-10+1		 Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 2 	1201				
Sta	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature					
Regist		JAN 1 3 2010	·				
DHMH 17 Rev 1/20	01	ORIGINAL					

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Madalyn Elaine KELLER Medical aniar 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital Washington Hagerstown Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July 18, 1929 9. Birthplace (State or Foreign Funeral 7. Age (In vrs. last birthday) 1 □ M 2 😾 F 213-24-9304 80 Maryland Director Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location must be notified at 10d, Inside City Limits **Funeral Director** Maryland Washington 1 Yes 2 X No Hagerstown 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 18034 Sand Wedge Drive 21740 USA or items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 ☐ Yes 2 🙀 No If Yes, Give þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white "natural", Completed 3 X Widowed 4 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) cafe manager food service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Paul Shank Olif Palmer and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health i item 27 i Janice Moats - daughter 1102 S. Potomac St., Hagerstown, Maryland 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1
Department of
Important: If it
any injury or o 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mountain View Cemetery 1/15/10 Sharpsburg, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ ONCESTIVE Medical Examiner resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last ORONARY and Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Year Pregnant at time of death the Unknown 9 Unknown P.O. signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by RENAL FAILURE PNEUMONIA. Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? MOLLITUS 24a. Was an has autopsy Yes 2 No 2 🗆 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) a No ပ္ 1, Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of Certificate: 28d. Describe how injury occurred eral Director: After filled in by the funera To the Hospital or Attending Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State To the Funeral Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, dea ath occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 138892 1/13/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JUITE HACERSTOWN 6H-6 1-04 ADFORD 1110

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year 2010 10:46a M <u>John Joseph Kelly</u> January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 2510 Coach House Way Frederick <u>Frederick</u> Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday 8. Date of Birth **Funeral** (Month, Day, Year)
July, 19, 1927 Months Days Hours 1 🛣 M 2 🗆 F Yrs Director 220-20-9533 Marvland Usual Residence of Decedent 28a-f shov 10a. State 10b. County 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Directo 1 X Yes 2 □ No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21702 2510 Coach House Way Unit United States 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2 🙀 No If Yes, Give 1 Yes 2 No Specify: Completed 3 Divorced Specify: White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. 10 Advertising <u>Machine Operator</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 John J. Kelly <u>Myrtie M. Beasley</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) pernit. Page 1 and 2 sh Deportment of Health ar Important: If item 27 is any injury or other trau Christine Whitaker/ Daughter 6824 Whistling Swan Way, New Market, Maryland 21774 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lakeview Memorial Park1/9/2010 Skyesville, Maryland 21. Signature of Juneral Solvice Ligens 22. Name and Address of Facility Stauffer Funeral Homes P. A. 1621 Opossumtown Pike, Frederick, Maryland 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Myocardial In Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) as a consequence of) **Examiner** disease Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a cong quence of that initiated events Due to (or as a consequence of) resulting in death) Last physician a sthe burial-1 Physician/Medical attending ph IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Dav Year signed by the a ld be detached f 1 ☐ Yes 2 L 9 ☐ Unknown a 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ perfencion 1 Yes 2 No 3 Probably 4 Unknown plnods Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 s performed? Yes 2 N 2 No 1 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 2 No Other: 1 Yes ٩ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manger of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural 5 Pending 2 Accident
3 Suicide
4 Homicide death. neral Director: A filled in by the fu 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after determined hin 24 hours at the Funeral Completed filled Medical **Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Defitying Prysocians to the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2. 29b. Signature and title of certifie

State Regis<u>trar</u>

Baltimore, Maryland 21215-0036

Box 68760

P.0.

Records,

Division of Vital

Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

		For State Registrar	State of	of Marylan	-	artment of F rtificate of		Mental Hyg	iene _{eg. No.} 2	010	01495	
		1. Decedent's Name (First, Midd	fle, Last)					2. Date of Deat	h	Year	3. Time of Death	
Physicia /Medic		Mary Laskin						January	5, 20		2:58 A ^M	
Examin		4a. Facility Name (If not institution	on, give street and nu	mber)		4b. City, Town, o	r Location of Deat	h	4c. Cou	inty of Death	n	
and the same of th		Angels Garden	To 0	- A - (1		Silver If Under 1 Year		0 D-1 (D'4)		ontgom		
Funeral Director		5. Social Security Number 288-18-7523	6. Sex 1 ☐ M 2% ☐ F	7. Age (In yrs. I. 88	ast birtngay) Yrs.	Months Days	Hours Min.	(Month, Day,		Cot	nplace (State or Foreign untry)	
		Usual Residence of Decedent		00				Dec 25	1921	Conn	ecticut	
ryland how		10a. State 10b. County	/	10c. City	, Town or Lo	ocation					10d. Inside City Limits	
e Ma Ba-f s	Director	MD Montg	omery	Si	lver						1 ves 2 □ No	
or 2	Dir	10e. Street and Number				10f. Zip Code		1	0g. Citizen	of What Cou	untry?	
s 23a	Funeral	3210 N. Leisur		1vd. #60 edent Ever in U.S		20906		Specify Von er No	USA	Race - Amer	vion Indian	
ter de	Fun	 Marital Status Never Married 2 ☐ Mar 	Armed F	orces?	5. 13.	Was Decedent of H If Yes, specify Cub	an, Mexican, Puer	to Rican, etc.)		Black, White		
urs af	δ	3 ₩idowed 4 Divorced	If Yes, G	ive		1 □ Yes 2 🙀 No	Specify:		Spe	ecify:	White	
72 ho	Completed	15. Decede	nt's Education est grade completed)		16a. Dece	dent's Usual Occup	oation	rkina	16b. Kind o	f Business/I	ndustry	
ithin ne. nan "	mple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of work done DO NOT use retire	d)	, and				
led w tygiel her ti											wn Home	
2. should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show raumatic event, it a Macilcal Evertime or ust by notified at	Be o	Morris Bravo	, Lasi)					1 Afram	naiden Sun	iairie)		
should be mark	은	19a. Informant's Name/Relations	ship (Type, Print)		19b. Mailii	ng Address (Street	wn. State. Z	Tip Code)				
nd 2 salth a la 27 is r trau		Ellen R. Maltz						ookville,				
s 1 al		20a. Method of Disposition		20b. P	1	osition (Name of matory or other place				on - City or 1		
Page nent c		1 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (3 □ Removal from Specify)	State		em. Garde	i	-2010 C	lnev.	Mary	land	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan pagartment of Health and Mental Hygiene. Important: If the m27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Italian Evantiant or other traumatic event, Italian Evantiant or other traumatic event.		21. Signature of Funeral Service	Licensee	,	2:						irection INC	
80 E 8 9		MUCGVeenhui	√ Melissa Me	01597"""	10	91 Rockv	ille Pik	e Rockvil	le, M	iaryla		
Physician		23a. Part1. Enter the disease, of shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	t only one cause on	each line.		ter the mode of dyi			est,		Approximate Interval Between Onset and Death Years	
/Medical Examiner		resulting in death) Due to (or as a consequence of):										
	e.	Sequentially list conditions, if any leading to immediate	b. — Due to	or as a conse	ence of:					-		
uted d ansit	Examiner	Cause (Disease or injury	S									
be executed stcian and burial-transit		that initiated events resulting in death) Last	C. Due to	(or as a consequ	ence of):							
cate be executed shysician and the burial-transit	dical	d										
ertifica ling pl	Med	IF FEMALE:										
Attending Physician: The law requires that the death certific rdeath. setor: After this certificate has been signed by the attending p by the funeral director, page 2 should be detached for use as t	Physician/Me	23c. If yes, outcome of pregnancy 23d. Was decedent pregnant in the past 12 months? 1								Date of deli Month	very Day Year	
that the the period detail		Part II. Other significant condit	ions contributing to d	leath but not resu	ılting in the u	nderlying cause giv	en in Part I.	23e. Did tob	acco use c	ontribute to	the cause of death?	
quires n sign	d by	Severe Recurrer	nt Pancrea	titis				1 □ Ye	s 2 🔀 No	o 3□ Pro	obably 4 🗌 Unknown	
s been s should	Completed							24a. Was a		4b. Were au	topsy findings available	
The la	mo							autops perforn t 🗆 Yes 2	ned?	death?	completion of cause of	
ician: The lav certificate has ector, page 2	BeC	25. Was case referred to medica	al				26. Place of Dea	ath (Check only on		I L Tes	2 L/N0	
nysic nis ce direc		examiner? 1 ☐ Yes 2 ☐ X No	Hospital: 1	Inpatient 2 🗆	ER/Outpatie	nt 3 DOA Oth	ier: 4 🗆 Nursing F	lome 5 🔀 Reside	ence 6	Other (Spec	cify)	
ng Pł	.:i	27. Manner of Death 1X Natural 5 ☐ Pendi	28a. Date	of Injury oth, Day, Year)	28b. Time o Injury	Wor	ry at k?	28d. Describe ho	w injury oc	curred		
tendi leath. tor: A	1 Yes 2 Mo Nursing Home 5 Manner of Death 1 Natural 2 Accident 3 DOA Nursing Home 5 Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Manner of Death 28a. Date of Injury 28b. Time of Inju											
or Al after o Direc in by	ertif	4 ☐ Homicide determ	mined 28e. Place	e of injury - At no ling, etc. (Specif)	me, farm, str	eet, factory, office		City or Town		umber or Ru	iral Route Number,	
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical C		ing Physician: To the I Examiner: On the I and mar									
To the comp	Me	29b. Signature and file of certific	er dv		7	29c. Licens	08381	1		gned (Month	n, Day, Year) 2010	
		30. Name and address of person	who completed cau	,								
		Dr. Benjamin A 31. Date filed (Month, Day, Year,					nilip Dr,	, St.209,	01ne	y, MD	20832	
Sta Registra		JAN 0 7	2010 1	Registrar's Signat	bu	Med .						
		VIIII -	-									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2010 Mary A. Littlefield January 6 5:55 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Castle of Love Assisted Living Prince George's Upper Marlboro Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🕱 F Months Days Hours 12/30/1923 Director 002-16-5713 Yrs New Hampshire 86 Usual Residence of Decedent shov 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f MD Prince George's Bowie 1 X Yes 2 No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? f Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a oi other traumatic event, the Medical Examiner must be Funeral 1707 Peppertree Court USA Page 1 and 2 should be filed within 72 hours after death 1 ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married à Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: 3 X Widowed 4 ☐ Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working Die Casting life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Administrative Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Antonio Prestipino Virginia Patti 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roy E. Littlefield/Son 1707 Peppertree Court, Bowie, Maryland 20721 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or ot Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Riverside Cemetery 01/09/2010 Milford, New Hampshire 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Beall Funeral Home <u>6512 NW Crain Hwy.,</u> Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysiciani Pleural Effusions disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Coronary Heart Disease Sequentially list conditions, ii any, reading to immediate cause. Enter Underlying Due to (or as a consequence of) and I-transit Exami Cause (Disease or linjury The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 🔀 No Pregnant at time of death ed by the a signed h Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Records, Completed Alzheimers Disease 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy this certificate 1 ☐ Yes 2 XNo 1 Yes 2 No Division of Vital Hospital or Attending Physician: 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? Other: 1 🗌 Yes 2 😾 No ျှ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (SpecifiAssit.Living within 24 hours after death.

To the Funeral Director, After th completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 1 Tyes 2 🗆 No ☐ Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a, Certifier 1 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 [only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signatu nd title of certifier 29d. Date signed (Month, Day, Year) 10 100545 61 30. Name and address of berson who completed cause of death (Item 23a) (Type, Print)

Registrar

State

William J.

31. Date filed (Month, Day, Year)

JAN 0

Crittenden

32. Registrar's Signatur

1160 Varnum St. NE Washington, D.C.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 01497 State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2:00 a M Wandalene Crow Montague January 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Nursing Home Rockville Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🛛 F Months Days Hours Min. 1278971925 West Virginia 233-36-8297 Director 84 Usual Residence of Decedent f show ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director Maryland Montgomeru Dickerson 1 Yes 2 1 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 19320 Wasche Road 20842 U.S.A. filed within 72 hours after death Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Yes 2 No Completed by Baltimore, Maryland 21215-0036 1 Tes 2 No Specify: If Yes, Give "natural", 3 💢 Widowed 4 🗆 Divorced Specify White Year or Dates the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Bookkeeper Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Russell Crow Grace Reynolds 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u> Karen Bowen - Daughter</u> Dickerson, Maryland 20842 19320 Wasche Road. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place 1 💢 Burial 2 🗌 Cremation 3 💢 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cunningham Mem. Park | 01/10/2010 | St. Albans. WV 21. Sign ture of Fun and Service 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 1800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ethysician/ disease or condition resulting in death) Breast Cancer Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): that the death certificate be executed Cause (Disease or imjury and that initiated events resulting in death) Last Due to (or as a consequence of): burialattending physician for use as the buria Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 X No 5 Other (specify) Pregnant at time of death Month Day Year 1 Yes 2 2 9 Unknown P.O. I ed by t sate has been signed I page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, Hospital or Attending Physician: The law requires Completed 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 X No 1 Yes 2 No director, Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 🗓 No Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 🗓 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral ι 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 X Natural injury 5 Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the pasts of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifie H0051280 January 06, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

10110 Molecular Dr., Suite 206, Rockville, MD 20850

D.O.,

2. Registrar's 810

Anushiravan Dadgar,

31. Date filed (Month, Day, Year)

JAN 08 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1 - State AMEND#23a(a-c)perMD1/12/10, BW.McCo
Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2010 Nathan MILLER **Physician** 6, 10:30 PM January /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a, Facility Name (If not institution, give street and number) Examiner Montgomery Takoma Park Washington Adventist Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month) Days Hours Min. Oct. 27, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) ^{Year)} 1909 **Funeral** Washington, DC 100 Director 577-48-0667 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Director Silver Spring Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ō death with United States 20910 1316 Fenwick Lane #1219 Items 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 💢 No 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 ∐Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No ō Specify Specify: 5 white 3 ☑ Widowed 4 ☐ Divorced "natural", Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ulth and Mental Hygiene. 27 is marked other than " r traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Grocery Store Grocery Store Owner 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Louis Miller Ida Tudor ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1121 University Blvd., W., #1411, Silver Spring, MD 19a. Informant's Name/Relationship (Type. Print) Margo Berg, Granddaughter Department of Health a Important: If Item 27 is any Injury or other tra once. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 01/10/10 Adelphi, MD Lebanon Cemetery Mt. 21. Signature of Fineral Service Livensee Torchinsky Hebrew Funeral Home 20012 254 Carroll St., NW, Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition Approximate Interval Between Onset and Death **Physician** disease or condition resulting in death) /Medical (or as a consequence of) Examiner Edem Pulmonary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed **Emphysema** sician and burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760; attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 5 ☐ Other (specify) sate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After t Natural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a 29a. Certifier ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical completely within 2 To the F and manner stated. the 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) and title of certifier 5 Shailendra 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1 ac Registrar's Signatu State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Year Thomas EARL 1:30 P M MARTIN /Medical JANUARY 2010 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death HAGERSTOWN
If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Dec 5, RAVENWOOD LUTHERAN VILLAGE WASHINGTON 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Funeral 9. Birthplace (State or Foreign 1**X**☐ M 2 ☐ F 214-14-6069 Director 1916 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, its Marical Evaluates and once. 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Funeral Director 1 ☐ Yes 2 No Maryland Washington Hagerstown 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 1183 Luther Drive 21740 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 S S 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 □ Divorced Specify: White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Farming 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Cleveland Martin ပ Carrie A. Luna 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gary L. Martin / Son 11400 Gehr Road Waynesboro, Pennsylvania 17268 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rose Hill Cemetery 101/16/2010 | Hagerstown, Maryland 21. Signature of Fun A Service Licensee 22. Name and Address of Facility Bast-Stauffer Funeral Home, P.A. 7606 Old National Pike Boonsboro, MD 21713 23a. Part 1. Enter the disease, or complications that raused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each lin. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Mohary artery disease 19/15 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician and for use as the burial-tra Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year signed by the a 5 Other (specify) 9 I Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? certificate has t rector, page 2 s 24a. Was an autopsy performe 1 ☐ Yes 1 ☐ Yes 2 (No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Unursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 1 Natural 2 Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation after death.

Director; A d in by the fu 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D28365

State

Registrar

SH-8

30. Name and address of person who completed cause of death

JAN 14 2010

31. Date filed (Month, Day,

nul

tem 23a) (Type, Print)

Hester.

Pegistrar's Signature

			For State	State of Maryla				Mental Hy	giene	110	01500
			Registrar 1. Decedent's Name (First, Middle, Last)		Ce.	rtificate of L	Jeath	2. Date of De	Reg. No. C	/ 1 U	3. Time of Death
	Physici		201	NETH MI	LLS			Month In N	Day	Year Zo IO	8:13 PM
do	/Medic Examir		4a. Facility Name (If not institution, give str			4b. City, Town, or	Location of Death	- 17 N	4c. County	-	4713
	Funeral Director		5. Social Security Number 6. Sex 1 X N	7. Age (In yrs	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birl (Month, Da OCT 26	th	Coun	lace (State or Foreign
	and w		Usual Residence of Decedent 10a, State 10b. County	10c. C	City, Town or Lo	cation				1	0d. Inside City Limits
	Mary Ind	tor	Maryland Washingto	n K	noxvill	٩					1 □Yes 2 【XNo
	or 28	Oirec	10e. Street and Number		.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	10f. Zip Code			10g. Citizen of \	What Coun	try?
	ath wi	rall	2434 Kaetzel Road			21758			U.S.A.		
10	filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or items 23a or 28a-f show ont, the Modical Examinat must be notified at	Funeral Director	11. Marital Status 12 1 □ Never Married 2 □ Married	. Was Decedent Ever in t Armed Forces? 1 □Yes 2 □ No		Was Decedent of Hi If Yes, specify Cuba	ispanic Orlgin? (Sp in, Mexican, Puerto	ecify Yes or No Rican, etc.)	- 14. Rad Blad	ce - Americ ck, White, e	
5-0036	urs af		3 ☐ Widowed 4 ☐ Divorced	1 ∏Yes 2 ☐ No If X es, Give Year or Dates:	948	1 □Yes 2 X No	Specify:		Specify	Wh	nite
5-0	72 ho 'natur	Completed by	15. Decedent's Educat (Specify only highest grade of	tion completed)	16a. Dece	dent's Usual Occupa kind of work done d DO NOT use retired	ation during most of work	ing	16b. Kind of B	usiness/Inc	lustry
2121	within ene. than '	ldmo	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired, Iblasting)		Мари	factu	mina
id 2	il Hygi other ent, I	Be C	17. Father's Name (First, Middle, Last)		June	DIUSCING	18. Mother's Nam	e (First, Middle,			ring
Maryland	should be fi and Mental b s marked ot umatic ever	To E	Howard Mills				Alt	ie_Down	S		
Jar	2 sho h and is ma raum		19a. Informant's Name/Relationship (Type	,		ng Address (Street &					*
	1 and Health em 27 other to		Paul R. Mills / Son			84 Kaetze:		Date	, Maryl		
mo m	Pages nent of I int: If ite		1 ☐ Burial 2 ☐ Cremation 3 ☐ Ren 4 ☐ Donation 5 ☐ Other (Specify)	loval from State		sition (Name of natory or other place 1 A Hats (, Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Wedical Examiner must be notified at once.		21. Signature of Funeral Service Licenses	re Dolla	22	2. Name and Addres	ss of Facility Ba	st-Stau	ffer Fu	neral	Home, P.A.
NEW YORK	Physician		23a. Part 1. Enter the disease, or complica shock or heart failure. List only one Immediate Cause (Final disease or condition	cause of each line.	ath. Do not ent	er the mode of dyin	g, such as cardiac				Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to or as a conse	quence of):	THEVES =	1				
	_	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	quence of):	THEVES	loves			-	1/3
	scuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
60,	fficate be executed g physician and s the burial-transit	al Ex	resulting in death) Last	Due to (or as a conse	quence of):						
68760,	ficate phys s the	edical	d								
O. Box	Hospital or Attending Physician: The law requires that the death certificate be executed A hours after death. Fuheral Director: After this certificate has been signed by the attending physician and tely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3 [Ectopic pregnancy Other (specify)	/			te of delive	ery Day Year
ď.	res that signed b be deta	by Pt	Part II. Other significant conditions contri	buting to death but not re	sulting in the u	nderlying cause give	en in Part I.	23e. Did to	obacco use cont	ribute to th	ne cause of death?
ord	w require s been sig should b	ted t		Atotos				1 🗆 1	/es 2 □ No	3 ☐ Prob	abiy 4 🔀 Unknown
of Vital Records,	ian: The law r rtificate has bo tor, page 2 sh	Completed						24a. Was autop perfo 1 Yes	rmed?	Were autop prior to cor death? 1 ∐ Yes	psy findings available mpletion of cause of 2 □ No
Vita	Physician: r this certific ral director, I	Be	25. Was case referred to medical examiner?	pital:		othe	26. Place of Deat				
of	y Physer this eral di	۲: ۲	27. Manner of Death	28a. Date of Injury	28b. Time of	IL SIN DOA	4 LI Nursing Ho		dence 6 Oth		0
ion	uttending Fideath.	atio	1 Natural 5 ☐ Pending 2 Accident investigation	(Month, Day, Year)	Injury		? Yes 2 □ No				
Division	al or Atte s after de al Directo ed in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At I building, etc. (Spec	nome, farm, str	eet, factory, office		28f. Location (S City or Tou	Street and Numb vn, State)	er or Rura	l Route Number,
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical (29a. Certifier (Check only one) 1 Certifying Physic 2 Medical Examiner	ian: To the best of my kr r: On the basis of examir and manner stated.	nation and/or in	vestigation, in my or	pinion, death occur	red at the time,	date and place,	and due to	tated. the cause(s)
	To the within 2 To the complex	Σ	29b. Signature and title of certifier	0 1 1 0		29c. License	number		29d. Date signe	d (Month, I	Day, Year)
			Kond Will	beck Med	>	000	11266		JAn	13	2010
5+	1-8+1		30. Name and address of person who comp	pleted cause of death (Ite	em 23a) (Type,	29c. License 7 0 0 Print) NorTkun	Av 11	Alexand	maria de	m	<i>)</i>
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature	1,007	171	0717	1 on N	11,30	
	Registr	ar	JAN 1 4 2010	1	1 1	and I					

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